PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

The National Health Program

and Public Health Nursing

AT THE MEETING of the Board of Directors of the National Organization for Public Health Nursing held in New York City, January 25, 1939, the report of the special committee to confer with the Interdepartmental Committee to Coördinate Health and Welfare Activities in Washington* was accepted. The committee had the privilege of meeting with representatives of the Technical Committee on Medical Care in Washington on December 16. The following statement was prepared, and by vote of the Board transmitted to Josephine Roche, chairman of the Interdepartmental Committee, on January 28, 1939.

The Board of Directors of the National Organization for Public Health Nursing, meeting on January 25, 1939, in New York City, approved the following statement for transmittal to Josephine Roche, chairman of the Interdepartmental Committee to Coördinate Health and Welfare Activities, Washington, D. C.

1. The National Organization for Public Health Nursing is in accord with the recommendation of the American Public Health Association that a single state agency should be administratively responsible for the provisions of the National Health Program which may be enacted into law. We believe this agency should be the state health department. It would be expected that the responsible department would assume leadership in planning for the coördination and utilization of the experience and services offered by all official and voluntary agencies. Within the health department there should be a bureau or division of public health nursing under the direction of a qualified public health nurse. Should special phases of the health program develop, special consultants responsible for advisory service to these programs should be added to the bureau.

We recognize that the counsel of qualified advisers from the medical, dental, and nursing professions will be requisite; that adequate provision for technical staff, administrative expense, and increased funds for training of personnel will be essential to successful performance.

2. We agree with the recommendations of the National Health Program that the fundamental objectives involved are the conservation of health and the reduction of sickness as the cause of dependency and poverty.

In the development of the program, we believe that the following services should have attention:

a. Expansion of public health service to reach all people. This expansion should include a plan for home nursing care for the sick.

*See The Need for a National Health Program, Report of the Technical Committee on Medical Care, reviewed in PUBLIC HEALTH NURSING, May 1938, page 332. The report is available from the Interdepartmental Committee to Coördinate Health and Welfare Activities, Room A-202, 1624 Eye Street, N.W., Washington, D. C.

See also, "The National Health Conference," by Ruth Houlton, September 1938, page 546.

b. In view of the great need for health supervision of the worker at work, expansion of the present medical and nursing services in industry, especially the small industries.

c. Expansion of maternal and child health services with emphasis on the development of adequate medical and nursing care at time of delivery, and care of the premature baby and the handicapped child.

d. Expansion of hospital, clinic, and other institutional facilities and the provision of medical and nursing care for the medically needy, recognizing the desirability of putting to use the already existing facilities provided by voluntary agencies.

3. We believe that:

a. In the initiation and development of this program, wide latitude should be given the states in the definition of population to be served, in the selection of the method of providing medical and nursing services, and in the use of already existing voluntary agencies through a combination of services under the leadership of the health department.

b. A continuing program of interpretation to lay groups and the use of citizens on counseling committees will further the aims of this national program.

c. Funds for study and evaluation of program should be made available to determine the future needs.

4. We believe that adequately trained personnel is of paramount importance to the success of this program. Essential to this are the following:

a. Sound basic courses in schools of nursing.

b. Graduate courses in general and special phases of public health nursing.

c. Provision for supervision and continuous in-service training.

d. The recognition of the personnel and training standards recommended by national professional organizations.

e. Special allotment of funds for the above training purposes.

5. We further believe that adequate personnel is so important to accomplishing the objectives of the National Health Program that federal and state aid should be dependent on the maintenance of reasonable standards in this regard.

6. We believe that recent experience has shown that the Social Security Act provides a suitable framework for the expansion of health service.

7. If any state should establish an insurance system to take care of the needs of the medically needy, we recommend that nursing services of a standard acceptable to the professional organizations be included in the benefits of the plan.

SPECIAL COMMITTEE OF THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING TO CONSIDER THE NATIONAL HEALTH PROGRAM

Grace Ross, President, Board of Directors, N.O.P.H.N.; Director, Division of Nursing, City Department of Health, Detroit, Mich.—Chairman.

Mary Beard, Member of Board of Directors, N.O.P.H.N.; Member of Board of Directors of American Nurses' Association; Director, Nursing Service of The American Red Cross, Washington, D. C.

Mrs. Charles S. Brown, Member of Board of Directors, N.O.P.H.N.; Chairman, Nursing Committee of Henry Street Visiting Nurse Service, New York, N. Y.

Mrs. S. Emlen Stokes, Member of Board of Directors, N.O.P.H.N.; President, Moorestown Visiting Nurse Association, Moorestown, N. J.

Marion J. Sheahan, Member of Board of Directors, N.O.P.H.N.; Director, Division of Public Health Nursing, State Department of Health, Albany, N. Y.

Elizabeth G. Fox, Member of Board of Directors, N.O.P.H.N.; Executive Director, Visiting Nurse Association, New Haven, Conn.

Dorothy Deming, Secretary of Board of Directors, N.O.P.H.N.; General Director, N.O.P.H.N., New York, N. Y.—Secretary

The resolution of the joint boards of the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing on the national health program is published in *The American Journal of Nursing* for March.

The Forgotten Child

By DOROTHY B. NYSWANDER, Ph.D.

The "normal" child is the forgotten child in the school. The nurse who uses modern educational techniques can, however, extend her service to all the children

WE HAVE HAD much talk during the depression about the "forgotten man." But he was a difficult fellow to identify at times because he seemed to be anyone and everyone. Not so with the "forgotten child." You can locate him in any classroom in any school. I would make an exception of the experimental schools only.

He usually occupies a seat toward the middle of a row. He is washed and neatly dressed. He is even-tempered. He does not get into fights while waiting in line. He does not wave his hand wildly in the air every time a question is asked in class. He is seldom absent from school. When he is absent a reassuring little note from his mother makes further investigation unnecessary. He is not the handsome boy in the class, or the brilliant boy. He is neither the handicapped boy nor the boy of slow wit. He gets about three questions right out of every four he tries to answer. He is not a special problem to a single person in the school. He is not even one of those little chaps the psychologists talk so much about—the kind who does a lot of daydreaming, is extremely sensitive, and is starting to build a little world within his own ideas and emotions that is more satisfying to him than the one we are trying to build for him. No, he is the child whom you and I for lack of better definitive terms call *normal*. And he is the "forgotten" child.

Perhaps you think our "forgotten" children are in the minority. They are not, at least when it comes to the health services we render. If we omit the incidence of carious teeth, a condition which after all does not call for the services of a physician and a nurse, approximately three out of every four children in our schools have no defects of a nature demanding the persistent attention of the school medical and nursing personnel. What does this mean? In a practical situation it means that the nurse, carrying a heavy case-load either in a specialized school service or in a generalized service, devotes a major part of her attention to the 25 percent who have some serious health problem. These children certainly have first call on her time.

A public health program is however, supported by tax money on the assumption that its services are for the good of all the people in a community, not a selected few. And if all are to be served, certainly the path which we must follow is clearly defined. If the school nursing personnel possess certain knowledges and skills which, because of their specialized professional training, are their particular contribution to child growth and development, these knowledges should be available to all children. If this thesis is sound we must seriously consider the implications.

Let us first analyze the major objectives of the nurse's work with school children; then the functions she performs to carry out these objectives. Perhaps by changing certain emphases and delegating a few of her responsibili-

ties she may be able to do more for the 75 percent of the children whom she meets but infrequently.

Primarily, the job of any school nurse today is that of educating: educating in ways of healthful living; in knowledges of how to remedy present health deficiencies and how to prevent future ones. She teaches just as the teacher does; only her field of action and her opportunities are different. All of the many things she does during the course of a week may be considered as the means she uses to accomplish her educational objectives. She routinely inspects contacts to a case of scarlet fever. She recommends that a child be excluded from school because he has impetigo. She gives to the school physician pertinent family history and information during the medical examination. She urges a mother to take her child to a private physician or to a clinic for a complete diagnostic "work-up." She asks a principal or teacher whether it would be possible to get better ventilation in a certain classroom. She keeps her individual health records for each child up to date. She interviews the social service and recreational agencies in her district. Whether the nurse reaches her educational objectives or not does not depend on whether she performs these duties. It depends on the *way* she performs them.

Most of the nurse's teaching is done with children and with their parents and teachers. These are three very different groups, and the nurse needs entirely different approaches to each. Yet her ultimate goals are the same. She wants parents, teachers, and children to know what healthy living consists of. She wants them to know how to anticipate health problems and how to act intelligently when these problems arise in the future. But *knowledge* about what should be done both now and in the future will not necessarily cause people to act differently. The nurse has an added responsibility, which is part of every modern educational venture, namely, that of conducting her teaching in such a manner that the child, the parent, and the teacher will *want* to put their knowledge into practice.

How does one get people to *want* to do things that appear desirable? That is the crux of the situation in health-education work. There is far too little experimental evidence to guide us here. We have too often been content with thinking that our job was done when proper instructions were given or appropriate pamphlets were distributed.

MOTIVATION FOR LEARNING NEEDED

For lack of specific experimental materials on this phase of our work in public health we turn to the field of classroom instruction to learn what school administrators and teachers are doing about the same problem. For it is the same problem. John Dewey and William Kilpatrick have long recognized it. Repeatedly during long years of inactivity on the part of the schools they have said over and over again: Knowledge without fundamental motivation arising from the child's own needs is soon forgotten. The school should be a place where a child lives, not where he learns to live. A child is not an assemblage of mechanical parts which operate at the will of someone who pulls the strings; a child is a dynamic living organism who is directing his own growth and shaping his own destiny.

It is only in recent years that the soundness of their philosophy, together with the results of experimental work in the classroom, has served to bring about a change in the methods of education. This change is affecting every school system in this country. Thus we witness entirely new types of curricula and new ways of guiding children, that, to the uninitiated, seem fantastic indeed. But we in the public health field have

much to learn from these ventures. For if the basic theory and procedures they are now advocating in the classroom are sound, we must review our own procedures. It would indeed be difficult to support the assumption that health education is an educational process differing from all other types of education.

If we regard the child as a "person" we naturally concern ourselves with his desires and interests. When we do that we have found the way to work with children. And adults learn in much the same fashion as do children. They, too, are seeking goals of their own which must be utilized if our work is to be effective. They, too, are always reacting in many ways to the situations in which they find themselves. They are making choices, liking, disliking, appreciating, scorning, thinking logically or illogically about this and about that. It is this fundamental understanding of how growth and change take place that we must have in our health work. *People want to follow a given path when they have had some part in choosing it, in making it, and in seeing its relationship to their other life interests and activities.*

Let us try to apply some of this theory, in order to see if it is practical; to see if its application may not so enlarge the scope of the school nurse's work that the greater part of her services will reach all of the children—not just a few. For Johnny, who is "normal," has just as much need for guidance in developing ideas of how to care for himself in the future as does Jimmy who has a specific health problem now.

REACH THE PARENTS

It is recognized now that in seeking to give health guidance to young children we should concentrate our efforts on aiding the adults who control, in large part, what the child will do or think or feel about his health problems. Little children cannot even understand what health means, for it is an abstract term. Growing children are not interested in health either. Watch them wriggle in their seats when someone starts talking about it. Only when a definite health problem prevents them from achieving something that is close to their desires and ambitions are they motivated to action.

This means that we must face this situation clearly, and, especially in the case of elementary school children, direct our explanations and counsel to the parents—not to the children. It means, too, that increased effort must be placed on getting parents to school at the time of routine or special medical examinations; that we must increase our effort to develop parent group meetings where the best methods available in parent education are utilized to provoke their participation in thinking through their individual and common problems. Such a program should reach all parents. If certain groups of parents cannot or will not come to a central meeting place, ingenious methods must be devised for taking the program to them. Reliance on parent-teacher groups, clubs, and other recognized agencies fails oftentimes to reach many parents. These parents have social groupings of their own; unless they are discovered and used, the community program is vitiated through the lack of their participation.

Whether we talk with parents in groups or individually, in school or at home, there are several criteria by which the success of our health education efforts may be measured.

1. The parent recalls the experience as having been both pleasant and helpful.
2. The parent believes that the nurse is cognizant of and interested in all of the problems which the family is trying to solve.
3. The parent is convinced that the nurse believes the family is able to assume responsibility for making intelligent choices in solving its problems.
4. The parent is confident that the nurse in her discussion of a child's physical defects is fully aware of the assets the child has.

5. The parent feels that he has received some professional advice regarding safe sources of medical care.

6. The parent recognizes that he has been presented with a sufficient background of facts from a professional source to serve as a basis for his future actions.

If parents feel this way about the nursing service they will *want* to have even more guidance. And more children and adults will be helped. But the evaluation of the nurse's work in terms of these criteria is difficult, if not impossible. It would be much easier to judge the success of the visit in terms of whether Mary went to the eye clinic or not. Similarly it is much easier to measure success in teaching geography by giving children a test to see how many names and facts they can remember. But if the objectives in teaching geography go beyond the mere recalling of names and facts, then such tests mean little in judging the results of teaching. The child who made 100 percent on the test may have the least understanding of the little foreign boy sitting in the next seat.

If a nurse believes that the results of her work are measured in units of "defects corrected," her educational influence may be narrow indeed. If, on the other hand, she accepts the criteria listed above and knows the techniques of carrying them out, her health teaching will have affected every member of the family. These techniques have become so habitual with many nurses that, using them, they do not recognize they are developing far-reaching health attitudes in the family. The mother is greeted by the nurse:

Good morning, Mrs. Smith. I want you to meet our school physician, Dr. Jones. We are both so happy that you could come in this morning for we think it extremely important that you should be here.

. . . . . .

I understand your problems, Mrs. Brown, and I think that you are solving them beautifully. Now would either one of these suggestions help you?

. . . . . .

You spoke of having two younger children. May I ask if you have had them immunized against diphtheria?

. . . . . .

The doctor could not find any cavities in Mary's teeth but you know and I know that the dentist or dental hygienist is the only person who can find the tiny cavities with an explorer and a mirror. Mary is such a lovely, healthy child. You would not want her to lose a single tooth unnecessarily. . . .

. . . . . .

Yes, baby teeth are important. We must watch them for these three reasons. . . .

So it goes. The nurse is a guide and a counselor and a friend. Such nurses bring mothers voluntarily to school year after year. There are no "forgotten children" in these families.

WORK THROUGH THE TEACHERS

It is really through the teacher that the nurse maintains her constant watchfulness over all the children. In reality, the nurse delegates some of her functions to the teacher. What are these functions? How does she teach the teacher to carry them out? Are the "forgotten" children reached in the process? To answer these questions let us visit a third grade classroom where a nurse is conferring with a teacher. For the purposes of brevity I will record only what the nurse says:

Good morning, Miss S. It was good of you to give me this appointment. But I know you are even more interested in your children than I am, for after all they are yours. Now which children have you observed that you think we should discuss together?

. . . . . .

You have noted on your health card that this child leaves the room frequently, that he has a slight speech defect, and that he looks very pale. Now tell me which row and seat he is occupying so that I may look at him. Don't call him to the desk because we would not want to embarrass him. My records show that his medical examination in the first grade

did not reveal any defects, but your observations may give the school physician some clues as to recent developments. Don't you think that we should have his mother come in the next time the doctor is here? Please tell me something about his school work and how he seems to get along with the other children.

. . . . . .

Yes, I know something of Jean, too, but your observations help to confirm what the doctor suspected might be wrong. Will you observe her carefully for another three months and let me know if she is absent with either colds or a sore throat. Then we will talk it over with her mother and the doctor.

. . . . . .

You are right. John was thought to have a heart difficulty when he was in kindergarten but he went to a good heart clinic where they obtained an x-ray and a cardiogram for him, and the clinic reported back that we should not worry further about him. They said, too, that he could enjoy full activity. May I write that on your health card for you so that all future teachers will know we should not consider John as a cardiac case?

The nurse spent one hour and fifteen minutes with that teacher. During this time they discussed each of 45 children in the class, finally selecting 10 to be seen with their mothers present when the physician came to school the next time. In addition to this exchange of information the nurse emphasized five points with the teacher.

1. That the growth charts the teacher was keeping were important, not because weight by itself means so very much but because losses or gains in weight over a six-months' period may be significant.

2. That the teacher should be complimented on her dental program. Every child but one had been to the dentist for an examination.

3. That the teacher and nurse should check on four children who were wearing glasses to see if they should return to the ophthalmologist for further adjustments.

4. That one child with a definite organic heart condition must be protected from drafts, colds, and overfatigue and tension.

5. That, since the teacher reported so many children biting their fingernails, the nurse thought it might be interesting if a list could be made of the school situations in which the children made this response. Was it because they were tired or hungry or afraid? Was it in the morning or in the afternoon?

Did this nurse reach the "forgotten" child? I think she did, for she had assigned to the teacher definite functions of (1) making observations of every child in the class (2) carrying out a systematic dental program (3) using growth charts as an incentive to child interest (4) studying child behavior in terms of seeking causes for such behavior. And she had shown her not only how to carry these functions out but how to interpret them.

These are ways of reaching the "forgotten" children.

TEACH THE CHILD CONFIDENCE

There are few children in a school—no matter how large it may be—who do not come in contact with the nurse some time during the year. Relatively few come in for medical examinations unless there is an annual medical inspection. Great numbers, however, come in (1) for removal of slivers in their fingers (2) following a few days' absence from school (3) accompanying younger children (4) bearing notes from teachers (5) suffering from minor disturbances—and for a dozen other reasons. Has the nurse something to give to each and every one of these children? Do the children know her name? Is she a stern, thin-lipped individual who barks at you as though she did not want to see you? Does she smile at you and say, "What can I do to help you?" Does she show you how to take care of yourself? Does she pat you on the back when she meets you? Does she preach at you? Does she whisper about you to other people in the room? Does she "bawl you out" in front of other children? Does she talk to your mother about you in front of you and make you angry? Or doesn't she speak to you at all when she meets you in the hall or on the street? Does she say "Thank you so much" when you bring her a note? Does she tell you "How nice you look this morning"?

What the nurse gives directly to the "normal" child depends on just such little things as these. The child learns confidence in nursing service as symbolized by the nurses he knows. He learns where to go or where not to go for help when in trouble. He learns either appreciations or prejudices that will go with him through life.

SUMMARY

What the school nurse gives to a few is needed by all children. There is no monopoly on health education. Every child needs it as part of his natural growing-up. And when the school nurse in actual practice uses her techniques to educate parents, teachers, and children to form sound attitudes toward health facts and health personnel she reaches all children.

It is our present stress on physical defects that keeps many of us from seeing the larger objectives. Just as the educator for so long a period lost sight of his reasons for teaching the multiplication tables and rules of grammar, so we have mistakenly assumed that a means toward an end was an end in itself. Children are dynamic creatures, changing while we look at them—becoming the adults of tomorrow's society. Our contacts with them in public health work must give evidence that we recognize our responsibility and our ability to serve them.

Courtesy of "All the Children"

An adult in the making

The Treatment of Allergy

By ROBERT CHOBOT, M.D.

The nurse plays an important role in referring the allergy patient to proper medical care and helping the family carry out the physician's instructions

IN THE COURSE of her day's work, the public health nurse sees a great deal of allergy,* diagnosed and undiagnosed, treated and untreated. It is of the greatest importance that she be able to recognize it, and that she understand thoroughly the principles underlying its treatment.

The most common of the allergic conditions are asthma, hay fever, and infantile eczema. In the case of asthma the diagnosis will frequently have been made by a physician long before the nurse sees the case. Asthma is a condition characterized by difficulty in breathing, or more specifically by the inability of the patient to exhale readily. Exhalation is accompanied by many wheezing and whistling sounds in the patient's chest, frequently audible several feet away. It is important to remember that asthma can occur in infants as well as in adults and the aged. The causes of asthma are many and various, and the cause must be determined before any treatment can be instituted; for this, medical aid is indispensable.

For the immediate relief of the acute attack, hypodermic injections of adrenalin are given. The technique of injections can readily be taught to some member of the patient's family; but they should always be given under the direction of a physician so that the dosage and frequency of injections may be controlled. It must, however, be borne in mind that adrenalin is a temporary measure, granting only symptomatic relief. The patient may soon become accustomed to it and develop a condition of tolerance to it, whereupon the treatment is no longer effective. For this reason it is imperative that the underlying causes of the asthma be found and treatment instituted.

We know that when various substances such as house dust, cat and dog hair, timothy and ragweed pollen, or any one of a number of other substances are introduced in solution form into the skin of a sensitive person, there appears at the site of injection a wheal with pseudopods which indicates a constitutional sensitivity. This fact is the basis for skin testing, and allergic patients must be tested to determine the cause of their trouble.

Once the cause of trouble is ascertained, treatment depends on the possibility of complete removal of contact with the offending substances. If this is feasible—as in a case of sensitivity to dog hair, where the dog can be removed—no further treatment is indicated. However, in many cases, immunizing injections must be resorted to because the offending substance can not be conveniently removed—as in the case of ragweed pollen.

REMOVE OFFENDING SUBSTANCES

The public health nurse should be aware of the fact that substances in the patient's environment may be extremely important causes of his asthma. She may perform a valuable service in the investigation of such substances in the home. It is not uncommon to find

*A definition of allergy appears on page 143.

pillows stuffed with rabbit hair or some other symptom-causing substance in homes. Should the patient be sensitive to this substance, removal of the pillow is immediately indicated. Likewise, mattresses stuffed with cotton containing the husks and hulls of cottonseed are frequently a cause of trouble. Other causes may be the orris root used in cosmetics and powders; and the hairs of cats, dogs, and other animals. It is not at all uncommon for some patients to use insecticides in their homes. Pyrethrum, which is contained in most insecticides, is a very potent cause of trouble.

The list of the substances causing trouble is very long but investigation frequently brings them to light. Removal where possible is always indicated. But some patients are very sensitive to substances whose removal is not practical, as for example house dust or orris root. Where casual contacts with these inhalants cause trouble, injections must be used to raise the patient's tolerance.

The nurse should suggest the removal of dust-gathering objects from the patient's rooms. She may also give advice regarding methods of sweeping and cleaning which will avoid unnecessary raising of dust. Certain foods are frequently important causes of difficulty, especially in children, and the nurse can be of great help in explaining the importance of adhering closely to the dietary regulations prescribed by the physician.

The principle underlying the treatment by injections is the same in both asthma and hay fever. After the cause of the asthma or hay fever has been determined by the physician, injections are administered to the patient. The solutions for the injections are very weak at first and their strength is gradually increased so that the patient's immunity is gradually developed. It is imperative to remember that no injections should ever be given unless there is a supply of adrenalin on hand. This rule must be strictly obeyed because overdosage can precipitate a generalized reaction consisting of itching, redness, sneezing, or asthma. These reactions can be severe and unpleasant, and cannot be controlled without adrenalin; fortunately their incidence is rare but the fact that they can occur must be borne in mind.

The usual procedure in treatment is to give the injections weekly for several months and then a decision as to their continuance and the interval between treatments is made, depending on the physician's judgment.

In the prognosis of asthma the patients must be divided into the groups that have complicating respiratory infections and those that have not. The prognosis in the group without complicating infection is good and the results often are extremely satisfactory and even brilliant. Where the cause of the patient's asthma is infection, the results vary, depending chiefly on the possibility of treating the infection—whether it be in the sinuses or in the lung. The success of the treatment of a patient having a removable focus of infection depends on the extent of the infection and the skill of the surgeon. In addition to surgery, vaccines prepared from the cultures taken from infected areas are also given.

RESULTS IN HAY FEVER TREATMENTS

The hay fever patient is, in about forty percent of the cases, a potential candidate for asthma if he remains untreated. Hay fever therefore should not be allowed to go untreated. The treatments should be started several months before the hay fever season and continued regularly during the season so that the patient may be exposed to the pollen, with freedom from symptoms. Results in the hay fever patients are satisfactory in at least eighty percent of the cases, and are therefore very worth while. It has been the experience of most allergists that the best results in

the treatment of hay fever are obtained when the injections are continued throughout the year at about three-week intervals. In this way the patient's dosage is maintained and it is easier to raise it to a higher level the following year if necessary.

The last condition to be discussed is infantile eczema. To the physician and to the nurse these children present a problem of great therapeutic difficulty. The treatment other than the diet outlined by the physician will depend for its success on the care with which it is administered.

In the first place the mother and family must be reassured and filled with confidence. They must be told that the baby will almost certainly get well. This is true since only a very small number of the infantile eczemas continue and develop into the adult form. They must be assured that no marks will remain as a result of the eruption; that, like all allergic conditions, it is not contagious; and that the child will grow up and thrive in spite of it.

The eczematous child must be kept in an environment where the temperature is constant at about seventy degrees Fahrenheit. His clothing should be light and cool. White cotton or linen should always be used in preference to rough materials.

The skin of the child should always be kept clean and soft and no soap should ever be used. Care should be taken that no soap remains in the clothing or bed sheets. In place of soap, baths with tepid water containing bran, starch, or oatmeal, or even some liquid tar in small quantities, should be used. After every bath, crusts should carefully be removed and oil applied to the skin, followed by some unscented talcum. In the cleansing process particular attention should be paid to the crevices and folds of the skin. Diapers of the infant must be soft and free of soap. After washing, diapers should be rinsed in a solution of bichloride of mercury 1:10,000. Some physicians prefer soaking them in a saturated solution of boric acid after they have been washed.

In addition to the local measures, it is imperative to observe carefully the dietary restrictions which the physician has outlined for the individual case. Obviously the removal of the offending food or foods, where they are causative factors, will result in complete relief of symptoms. This removal, together with meticulous care in local treatment, are the main factors in getting these children well.

Above all else, allergy requires a correct diagnosis, because without this accurate diagnosis proper treatment is impossible. The public health nurse may perform useful functions in the prevention and treatment of allergy. She may recognize the symptoms of allergic conditions and refer patients to proper sources of medical care. She may help to interpret the physician's orders to the family so that they will understand the importance of strict compliance. She may discover offending substances in the patient's environment, which are causes of allergic conditions. She may give skilled nursing care and teach the family those nursing techniques and procedures which are necessary to effective care of the patient.

DEFINITION OF ALLERGY

The term *allergy* is used today to characterize the hypersensitive conditions of man. We say that people are allergic when their response to certain ordinary substances which do not in any way affect the normal person is definitely abnormal. Nearly everyone has seen individuals who become ill when they eat eggs or chocolate, or who develop a rash after eating strawberries or other fruits. During the summer months the hay fever patient suffering with inflamed eyes and nose, many sneezes, and even attacks of asthma comes to the attention of everyone. These patients are hypersensitive and are called allergic. The term describes a bodily condition rather than a disease entity.

—From "Can Allergy Be Prevented?" by Dr. Chobot, in the May 1938 issue.

A Rural Home Delivery Service

By JAMES E. PERKINS, M.D., Dr.P.H., and FLORENCE B. WILLIAMS, R.N.

A study of the nursing assistance given at rural home deliveries in a two-county health district of the New York State Department of Health for the first six months of 1938

A DELIVERY nursing service was established in a two-county health district in New York State on January 1, 1938. The development of the service during its first six months and the policies governing the service are described here. This early study was made to determine the extent to which the service was being utilized, the adequacy of data being collected, and the desirability of altering any of the policies under which the service is operating.

The territory served is the Fulton-Montgomery Health District, which consists of two counties, each oblong in shape with the long axis running east and west. One county is immediately north of the other. The two together thus form roughly a square about thirty miles in each dimension, with a total area of about 900 square miles. The more southern of the two counties is Montgomery County, throughout the length of which runs the Mohawk River with its accompanying Mohawk Barge Canal (Hudson River to the Great Lakes), and the main line of the New York Central Railroad. The more northern of the two counties is Fulton County, extending in its northern half into the foothills of the Adirondacks.

Montgomery County has a population of 60,910, estimated as of July 1, 1938. It has one city, Amsterdam, with a population of 35,314, in which the chief industry is the manufacture of rugs and carpets; and ten incorporated villages, most of which are scattered along the Mohawk River throughout the length of the county. Dairying is the chief industry in the rural area of the county.

Fulton County has a population of 47,242, with 34,294 of this number in the twin cities of Gloversville and Johnstown (populations 23,493 and 10,801, respectively). There are, in addition, three incorporated villages in Fulton County, all on the shores of the Sacandaga Reservoir in the northeastern corner of the county. The Reservoir, a large lake about thirty miles long, has been produced by damming the Sacandaga River, a large tributary of the Hudson, for the purpose of preventing floods of the Hudson River in the spring and maintaining its level at a navigable depth in the late summer and fall. The rest of the county is very sparsely settled except in the summer, when numerous visitors flock to the Reservoir and to the numerous small lakes among the Adirondack foothills in the northwestern part of the county. The chief industry throughout the county is the manufacture of gloves.

MORTALITY RATES

The average annual number of deaths from puerperal causes per 10,000 total births for the five-year period 1932-1936, exclusive of the cities, has been 52.7 for Montgomery County and 55.2 for Fulton County, in comparison with a corresponding upstate New York rate of 55.8. The average annual number of deaths under one year of age per 1000 live births for the same period, and

again exclusive of the cities, has been 48.2 for Montgomery County and 67.0 for Fulton County, in comparison with a corresponding rate for upstate New York of 51.2.

NUMBER OF BIRTHS

In 1936 there were 1414 births in the two counties, of which 863 were born to mothers who were residents of the three cities. Of the remaining 551 births, 206 occurred in hospitals and 345 occurred at home. The system of nursing assistance at deliveries is designed for this last group; that is, those occurring at home in the areas of the district outside the limits of the three cities.

NURSING OFFICES

Prior to the inauguration of the delivery nursing service the nursing offices of the two counties were centralized in three places: (1) Amsterdam, utilizing the district headquarters there, (2) Gloversville, (3) Fort Plain. Office space, furniture, and a clerk were secured for the office in Gloversville and the one in Fort Plain, and telephone exchanges to receive night, week-end, and holiday calls were arranged for. Funds to cover these expenses for a two-year period were secured from the International Health Division of the Rockefeller Foundation.

The Amsterdam nursing office serves the towns of Amsterdam, Florida, Mohawk, Glen, Charleston, and Root, with a total population of 12,000. The Gloversville nursing office serves the towns of Bleecker, Johnstown, Northampton, Mayfield, Broadalbin, Perth, Caroga, and Ephratah, with a total population of 10,000. The Fort Plain nursing office serves the towns of Stratford, Oppenheim, St. Johnsville, Minden, Palatine, and Canajoharie, with a total population of 16,000. (See Chart I.)

The service is planned so that there will be a nurse on call at all times at each of the three nursing offices. There

Chart I

are three nurses working out of each office, or nine altogether; all are members of the regular staff of the district and entirely state-employed. This number of nurses was already assigned to the district previous to establishing the delivery service, and a further increase was not deemed necessary. (The district is serving as a rural training area for public health nurses for the State Department of Health, and more state-employed nurses are provided for this district than for most of them.)

It is apparent that with three nurses assigned to each office, each nurse will be on call on the average every third twenty-four-hour period, and every third week end. To compensate for this restriction of her activities she is allowed the Saturday morning off on the week following her week end on call. In addition, she is allowed to be off duty for overtime accumulated through actual work exceeding the regular working hours.

The nurses do not go on second call. If the nurse on call is already attending a delivery, a private duty nurse in the area, previously selected on the basis of training, ability, and availability, is called. She is paid by the State Department of Health through the Division of

Maternity, Infancy, and Child Hygiene at the rate of five dollars per delivery.

Each nurse has her own territory for her usual generalized public health nursing activities, as before, but in addition she keeps informed regarding any antepartum patients being carried by the other two nurses working out of her nursing office—since the nurse on call responds whether or not the case is in her own nursing area. A system providing information on all antepartum patients is necessary, therefore; and a notebook in which the nurses list every antepartum case as it is admitted to the service has been placed in each nursing office. These listings are made under the month that delivery is expected.

DELIVERY RECORD

Name _____ Address _____ Gravida ____ Para ____ Physician _____

Date registered for Antenatal nursing care Mo. _____ da. ____ yr. ____

Date delivery call received by doctor Mo. _____ da. ____ yr. ____ Time ____ a.m. p.m. Name of nurse _____

Time of arrival in the home: Physician ____ a.m. p.m. Nurse ____ a.m. p.m. Time left the home: Physician ____ a.m. p.m. Nurse ____ a.m. p.m.

Date of delivery Mo. _____ da. ____ yr. ____ Time ____ a.m. p.m. Nurse's travel time _____

Placenta and membranes delivered at ____ a.m. p.m.

Conditions on arrival in the home

Doctor present Yes ☐ No ☐

Patient: Up ☐ In bed ☐

Contractions: Frequency ____ minutes hour Show ☐

Quality _____

Duration ____ seconds Bleeding ☐

Membranes: Intact ☐ Ruptured ☐

General condition: T. ____ P. ____ R. ____ B.P. ____

Fetal Heart _____

Quiet ☐ Restless ☐ Fatigued ☐

Toxic Symptoms: _____

Complications: _____

Home preparation for delivery:

Sterile supplies ☐ Unsterile supplies ☐

Partial preparation ☐ No preparation ☐

Help adequate ☐

Pack furnished by _____

Illnesses or infections in household ☐ if present

Who _____

What _____

Relation to care of patient _____

Care and progress of labor

Preparation of patient for delivery: Shave ☐ Enema ☐ time given ____ Catheterized at ____ a.m. p.m. Voiding ☐

Mask worn by nurse during procedures: Yes ☐ No ☐

Condition of patient during	1st stage	2nd stage
Membranes ruptured		
Bleeding		
B.P.		
F.H.		
T.P.R., as indicated (2 times)		

Unusual symptoms: _____

Medications given; 2 time: _____

Remarks: _____

Delivery and Postnatal care

Masks worn by Physician: Yes ☐ No ☐ Nurse: Yes ☐ No ☐ Helper: Yes ☐ No ☐

Gown worn by Physician: Yes ☐ No ☐ Instruments sterile: Yes ☐ No ☐ Antiseptic solution used ____ (what)

Physician: Scrub 2 gloves ☐ 3 gloves ☐ Gloves 2 scrub ☐ Neither ☐

Gloves sterile ☐ Clean only ☐

Delivery: Spontaneous ☐ Operative ☐ Laceration ☐

Vertex ☐ Episiotomy ☐ Perineal 1° ☐ 2° ☐ 3° ☐

Breech ☐ Forceps ☐ Low ☐ Mid ☐ High ☐ Repair: Yes ☐ No ☐

Other, specify _____ Version ☐ Cervical ☐

Other, specify _____ Repair ☐

Anaesthesia _____ By whom administered _____ Physician present: Yes ☐ No ☐

Secundines delivered intact and complete ☐ Retained ☐ Incomplete ☐ Not examined ☐

Postnatal: Reaction of patient: _____ Pulse ____ Bleeding moderate ☐ Hemorrhage ☐ ____ cc

Fundus: Firm ☐ Muscle tone good ☐ Relaxed ☐

Medications given _____ Time given _____ by nurse ☐ by physician ☐

Mouth ☐ Hypodermic ☐ Other treatment, specify _____

Condition 1 hour Postpartum (state time, if earlier or later) _____

T. ____ P. ____ R. ____ B.P. ____ Appearance _____

Uterus: Firm ☐ Height above symphysis _____ Bleeding moderate ☐ Profuse ☐

Instructions left in home _____

Remarks _____

Infant

Sex _____ Temperature _____ °F Birth weight ____ lb. ____ oz. Eye Prophylaxis: Ag NO_3 1% ☐ Other ☐

Condition at birth: Good ☐ Resuscitation used ☐ Poor ☐ Stillborn ☐ Died ☐

Examined by Physician: Yes ☐ No ☐ Appeared normal ☐ Abnormalities _____

Voided ☐ Meconium ☐ Oil cleanse ☐ Water bath ☐ Sleep alone ☐

To be fed breast q ____ hr. after ____ Other feeding (state) _____

Chart II

The notebook provides for the following information:

1. Date admitted
2. Name of patient
3. Location (specific directions for finding)
4. Estimated date of delivery
5. Physician
6. Nurse carrying the case during the antepartum period
7. Nurse attending the delivery

If the patient is planning a hospital delivery, her name is starred with red ink. It was considered best to include all antepartum patients, since there might be a last-minute change in plans.

A spot map is also maintained on a detailed topographical map of the area, indicating the exact location of the home of each antepartum patient being carried.

In addition to the data recorded in the notebook, an individual nursing record is made by the nurse for each antepartum patient, utilizing the usual general form which provides for significant facts in the patient's past history, and data concerning medical care and nursing services received. At the time of delivery, a special report is filled out by the nurse giving detailed information concerning the delivery, and the condition of the mother and infant following delivery. (See Chart II.) This form, incidentally, is to be revised since it was found that certain desirable data cannot be obtained from this formulation of the report; it became necessary in this analysis laboriously to supplement data from this form with information from other records.

RELATIONSHIPS WITH PHYSICIANS

The service was established in response to a demand by the physicians practicing in the rural areas of the district who had been given this service in a more or less irregular fashion previously by Works Progress Administration nurses when they were available. In December 1937, the Montgomery County Medical Society passed a resolution requesting the district health officer to establish such a service.

When the service was started, a mimeographed bulletin was sent by the district health officer to every physician in the district. This letter explained the service and stated the policies under which it would operate. A small mimeographed pamphlet was also enclosed which, in addition to a brief description of the entire organization and program of the district, gave the addresses and telephone numbers of the three nursing offices, and the telephone exchanges for calls after hours.

In one territory this "after-hours" arrangement was made through a physicians' exchange; in another, through a maternity home, the telephone of which is covered continuously; and in the third through an intelligent cripple continuously confined to her home, and whose telephone, therefore, is also constantly covered.

POLICIES

The policies given in this physicians' bulletin are as follows:

Eligibility

1. The service is restricted to patients living in the district outside the three cities of Amsterdam, Gloversville, and Johnstown.

2. The district nurses are not to be used in place of private duty nurses if the latter can be afforded. Eligibility will be decided by the attending physician.

3. Since deliveries in hospitals are preferable, particularly for primiparæ, this service is not to be used for the purpose of delivering women at home who otherwise would have gone to the hospital.

4. The service is available only to women who have placed themselves under the care of a physician before the sixth month of their pregnancy, and have been referred to the respective district nurse for assistance in antepartum supervision.

Notification

5. Nurses are to be notified of a pending delivery through the nursing office clerk (or respective after-hours service), and the physician is to accept whatever nurse happens to be on call.

6. The notification must be by the physician, unless the party calling states that the physician has been notified and is also on his way.

Nurse without physician

7. If the nurse arrives first at the home, she will not stay longer than one hour if the physician fails to arrive.

8. The physician is not to leave the nurse alone with the patient, unless an actual emergency call comes in and it seems reasonably certain the physician will be able to return before the delivery.

9. Repeated failure on the part of a given physician to be present at the actual time of delivery will be considered sufficient cause for withdrawal of the service to that physician.

Dangerous roads

10. If the location of the home is very remote and the call at night, or if the roads are in a dangerous condition, the physician will be expected to arrange to meet the nurse at a convenient spot on a safe highway, and let her ride with him the rest of the way in his car.

It was explained to physicians that policy number four, requiring that in order to be eligible the patient must register for antepartum nursing supervision before the sixth month of pregnancy, was included in an effort to educate expectant mothers to place themselves under medical supervision as early as possible; and that in instances in which the physician himself had not been previously consulted the service would be given even though the month of gestation was beyond that specified.

After every delivery at which nursing assistance is given, one of the supervising nurses visits the physician to get any suggestions or criticisms he may have. If this is her first visit to him, the supervisor also gives the physician a mimeographed copy of the standing orders approved by the state medical society asking him to indicate changes he wishes the nurses to follow in the care of his patients. In this way the office card file of physicians with their standing orders is being revised and brought up to date.

NUMBER OF CALLS

A response to a call counts as actual assistance at delivery under two conditions: (1) Birth must have occurred (2) The nurse must have arrived before the delivery of the placenta. Responses to calls otherwise (false labor pains, et cetera) are counted merely as "other calls."

During the first six months there were 116 calls for delivery nursing assistance, 83 of which could be classified as "assistance at delivery," and 33 as "other calls." These calls by months and nursing areas are given in Table I. These figures show (1) that the demand was rather uneven, the Fort Plain area receiving over half of the total number of calls (2) that there was a progressive increase in the use of the service during the period under consideration. This second point is brought out graphically in Chart III.

TABLE I

Calls for nursing assistance at rural home deliveries received from January through June, 1938, subdivided according to nursing area and according to whether or not service at delivery was actually given

Month	Assistance at delivery				Other calls				Grand total
	Amst.	Glvl.	Ft. Plain	Total	Amst.	Glvl.	Ft. Plain	Total	
January	0	0	3	3	0	0	0	0	3
February	3	0	2	5	0	0	0	0	5
March	2	2	10	14	1	1	0	2	16
April	1	8	8	17	0	1	2	3	20
May	6	4	11	21	5	1	7	13	34
June	1	7	15	23	2	2	11	15	38
Total	13	21	49	83	8	5	20	33	116

TABLE II

Births occurring to residents of rural areas of the Fulton-Montgomery District during the period January through June, 1938

Month	Total	Hospital	Home	Home with nursing asst.	Percent home dels. with nursing asst.
January	35	16	19	3	16
February	32	20	12	5	42
March	49	22	27	14	52
April	41	18	23	17	74
May	58	14	44	21	48
June	45	12	33	23	70
Total	260	102	158	83	53

As to the thirty-three "other calls," these consisted of the following:

25 false labor pains
5 arrivals by the nurse after delivery of the placenta
2 transfers to the hospital, after preparation by the nurse, because of developing complications
1 failure to reach the home (bad roads—car became mired)

NUMBER OF BIRTHS

The births which occurred during this period to residents of the two counties, exclusive of the three cities, are given in Table II. From this table it may be seen that 158 rural home deliveries occurred, and nursing assistance was given at 83, or 53 percent of those deliveries.

ANTEPARTUM SUPERVISION

Incidentally, of the total number of 260 deliveries, the mothers were given nursing supervision during the antepartum period in 138 instances, or in 53 percent. These 138 antepartum cases were registered according to the month of pregnancy as follows:

Month of gestation	Number registering
1st month	0
2nd month	2
3rd month	4
4th month	10
5th month	19
6th month	11
7th month	37
8th month	21
9th month	34
Total	138

Or, expressing it in percentages by trimesters:

Trimester	No. registering	Percent registering
1st	6	4
2nd	40	29
3rd	92	67
Total	138	100

With two thirds of the patients registering after the second trimester, there

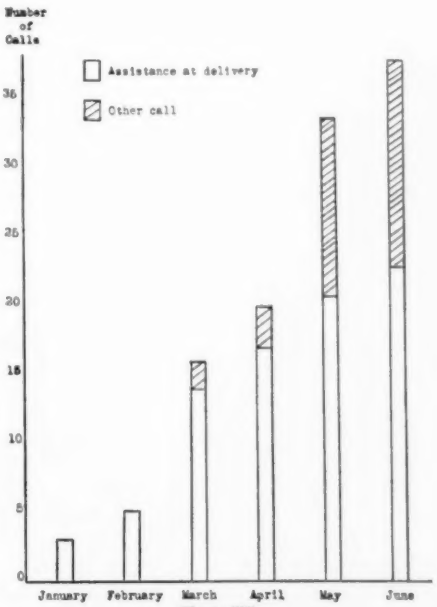


Chart III

Increase in the use of nursing assistance at rural home deliveries, Fulton-Montgomery District, January through June, 1938

is obviously much room for improvement.

Five hundred fifty-eight antepartum nursing supervision visits were paid to these 138 antepartum patients prior to delivery, or an average of 4 visits per patient. Incidentally, these antepartum visits do not include the thirty-three "other calls" mentioned above under responses to calls for delivery, although in the twenty-five "false labor" instances these calls actually became antepartum supervision visits.

TIME CONSUMED AT DELIVERIES

In the 83 delivery assistance calls, the nurses spent 53.5 hours in travel to and from the home, and 321.0 hours in the home itself, or a total of 374.5 hours, an average of 4.5 hours per call.

In the 33 "other calls," the nurses spent 22.7 hours in travel, and 65.2 hours in the home, or a total of 87.9 hours; an average of 2.7 hours per call.

UNFAVORABLE OUTCOMES

Unfavorable outcomes are indicated in Table III, so far as maternal deaths, infant deaths, and stillbirths are concerned.

From this it is obvious there occurred at or following the deliveries of the 138 women given antepartum nursing supervision the following unfavorable outcomes: 2 maternal deaths, 4 stillbirths, and 2 deaths (thus far) among the infants. From these figures one might calculate a maternal mortality rate of 145 deaths from puerperal causes per 10,000 total births, a stillbirth rate of 290 stillbirths per 10,000 total births, and a neonatal mortality rate of 15 deaths under one month of age per 1000 live births. The first two of these would seem to be very high rates. However, not only are rates based upon such small numbers unreliable, but a selective factor probably enters in since those women having a stormy antepartum course are probably more likely to be placed under supervision.

Data from which corresponding rates might be calculated for those *not* given antepartum nursing supervision are not available. However, such comparisons will be readily possible in the future since birth and death certificates now pass routinely through the District Office. (Started April 1, 1938.)

One of the maternal deaths was attributed to toxemia of pregnancy, premature separation of the placenta, and Caesarian section; the other to "shock," probably due to intrauterine hemorrhage following retention of the placenta.

Both infant deaths occurred in premature infants. Infant I had reached the eighth month of gestation and died

TABLE III

Unfavorable outcomes among the 138 cases given antepartum nursing supervision.

Unfavorable outcome	Month registered for antepartum nursing supervision	Delivery at hospital or home	Assistance by public health nurse
Maternal deaths (2)			
I	8th	hospital	—
II	4th	home	yes
Infant deaths (2)			
I	7th	home	no
II	6th	home	yes
Stillbirths (4)			
I	6th	hospital	—
II	7th	hospital	—
III	6th	home	yes
IV	9th	home	yes

eight days after birth; Infant II had reached the seventh month of gestation and died three hours after birth.

ACCEPTANCE BY PHYSICIANS

The service has been very well received by the physicians. There has been essentially no criticism of the nature of the service which the nurses have rendered, and there has been much praise. A few physicians have expressed the wish that the calls could go first to the nurse, having her call the physician when the patient is about to deliver. Ideal though this might be for the physician, the increased demand on the nurse's time and the responsibility placed upon her make such a change in policy seem undesirable.

There has been no evidence of abuse of the service by physicians. In only two instances was the nurse alone with the patient at the time of delivery. In each of these instances the physician, who was in attendance at another delivery, was able to provide medical assistance to the nurse before completion of the third stage of labor.

INTEGRATION WITH ENTIRE PROGRAM

This service has undoubtedly interfered to a certain extent with the other phases of the generalized nursing program. However, it is not thought that the rest of the program has been seriously curtailed; and in the opinion of the supervising nurse, the necessarily more critical evaluation by the nurse of her program and the allotment of her time has not been without its merits. Furthermore, in contrast with some of the other activities of public health nurses, this assistance at deliveries is a concrete, visible service appreciated by physician and patient alike. The good will to the public health program resulting from it justifies to a certain extent the curtailment of some of the other activities.

SUMMARY

1. An experiment of providing nursing assistance at rural home deliveries in a district consisting of two counties in the center of New York State is described. This district covers an area of about 900 square miles and has a population of about 100,000, of which 40,000 live outside the three cities of the district. Among these 40,000 individuals there occur annually about 550 births, of which 350 occur at home. The service is designed, therefore, for about 350 home deliveries per year among rural residents of the district.

2. Nine nurses, working in groups of three from three nursing offices strategically placed throughout the two counties, give this service as part of a generalized public health nursing program.

3. The nurses take turns being on call, each nurse being on call every third 24-hour period, on the average. Whichever nurse is on call responds to any call originating in the third of the district served by her nursing office, whether in the area served exclusively by her in her other generalized public health nursing work, or in the areas of the other two nurses working out of the same nursing office. The nurse on call is reached during working hours through the clerk in the nursing office, and after hours by a special telephone exchange arrangement.

4. In addition to time off for actual overtime, the nurses are compensated for restriction of activities due to being on call, by being allowed every third Saturday morning off, giving each a "long" week end every three weeks.

5. The policies governing the service are given and the development of the service during its first six months is described. Thus far, at least, the arrangement seems to be working very satisfactorily.

Prepayment Plans for Nursing

EARLY in November 1938 the National Organization for Public Health Nursing sent a letter to 300 public health nursing associations among its member agencies, to obtain information on group prepayment plans for providing nursing care in homes on a visit basis. The letter asked for the following data:

1. Is there a group hospital or group medical prepayment plan for service in your community which does or could include nursing care in the home on a visit basis?
2. If you are already participating in such a plan, please send us details of your plan.
3. If your plan is in process of formation, please let us know the stage of its development.

Within a month 175 replies were received and others are still coming in. Among the 175 answers, 3 gave insufficient information and were discarded. Of the remaining, 80, or about 45 percent, reported that no prepayment plan for hospital or medical care existed in their communities; while 92 agencies, almost 54 percent of the total, reported the existence of such a plan. Only 2 public health nursing agencies stated that they are now participating in the prepayment plans of their respective communities, but 14 others reported that they are working on plans or have approached the local hospital or medical group about them.

The Beneficial Society of San Diego, California, includes nursing visits in the home in its plan. The Visiting Nurses of San Diego have been giving this service on a cost basis for nearly a year. Their director reports that the number of visits allowed to any type of case is based somewhat on the plan of the Metropolitan Life Insurance Company. However, the Beneficial Society allows extra visits in any case where the nurse considers it necessary.

In Seattle, Washington, there is a group arrangement called the King County Medical Service Bureau. Home visits by visiting nurses will be paid for by the Bureau, but the director of the Seattle Visiting Nurse Service reports that so far this type of service has not been emphasized and few cases have been referred to the organization by physicians. When cases are referred, service is paid for at the rate of $1.25 for each visit and the only limitation set seems to be that care shall not be extended beyond six months of illness.

As was to be expected, a large percentage of replies to the questionnaire expressed interest and requested further information. For one thing, there was a general recognition of the increased opportunities for service such a plan would give. Public health nurses have long realized that there is need in almost every community for nursing service to those able to pay a small fee.

Another reason for interest in prepayment plans for nursing is the hope that by means of it, increased income may be secured, since many public health nursing associations are suffering from reduced budgets at this time.

One agency reports efforts toward securing participation in the hospital plan of their city as follows:

> The visiting nurse association has been working for the past two years, or ever since the hospital plan was organized, on the possibility of becoming a part of it. The hospital project is still young but has grown rapidly and has been very successful. Like other successful insurance schemes, as the surplus grows new services must be offered or the rate must be reduced. I want visiting nursing to be one of those added services. I honestly do not think it will increase our income, at least for some time, but I do feel it would be a very wholesome connection for the patient, the hospital, and the visiting nurse association.

A group of visiting nurse associations in Westchester County, New York, have

gone further than any others which reported, in investigating possibilities and initiating a project for the inclusion of visiting nursing in a group hospitalization plan. Mr. Charles F. Neergaard, who was chairman of their study committee, has written of their tentative project in *The Modern Hospital* for December 1938. He states that:

> While the study indicates that the group plan applied to visiting nursing is needed, is desirable, and probably would be salable, it has been felt from the beginning that it would be practical only if organized and offered to the public on a family basis as an extension of the benefits of the group hospitalization plan. Legal aspects are being investigated and a joint committee representing the nursing and hospital interests is to consider the many practical details that must be settled before it can be determined whether such a group prepayment plan can be offered to the public. . . . there are many unknown factors, and definite actuarial figures are essential to any general adoption of the plan. It is the hope that, with Westchester County as a proving ground, a year's experiment may be carried on with 5000 of the 22,000 families now members of the 3-cents-a-day hospital plan to yield definite facts on demand, use, cost, and value of group prepayment nursing in the home.

The visiting nurse associations of Westchester County thus have pointed the way for other public health nursing agencies in areas where group hospitalization plans are in effect.

Steps toward securing inclusion in such a plan might be:

1. A study of the nursing service such as was made in Westchester County of:

   a. The volume, character, and cost of visiting nursing.

   b. The extent and nature of the present demand for service.

   c. The extent of possible use of visiting nurses in the after-care of hospital patients, according to the opinion of medical staffs.

   d. The opinion of residents of the area concerning the idea.

2. The use of facts obtained by the study to help sell the idea to those directing the existing group plan and to the public.

3. An investigation of the state insurance law to determine whether such inclusion would be legal or whether amendment of the law may be necessary.

4. The formation of a joint committee of hospital and nursing groups, and the undertaking of experiments to determine how and under what conditions a group prepayment plan for giving visiting nurse service can best be arranged.

Those who have given most attention to this problem believe that any prepayment plan for nursing should be part of a larger project which includes hospitalization or medical care because otherwise the volume of payments will not be sufficiently large to make the plan practical from the actuarial point of view.

It is thought that the use of this type of service will be more difficult to control than hospitalization. It is also believed that definite efforts will be necessary to sell memberships which include visiting nursing because this type of care in the past has often been limited largely to the indigent sick, and others have not experienced its value to any great extent.

In commenting recently on the idea of prepayment plans for nursing service, a thoughtful and experienced public health nurse said, "In spite of the difficulties with regard to details, this seems to me profoundly significant. I think it points the way to possible next steps in visiting nurse service that will serve as a sound basis for any real health insurance plan which may later eventuate."

At any rate, the brief survey of public health nursing associations made by the N.O.P.H.N. at the close of 1938 indicates that they are increasingly aware of the possibilities to be found in such plans and that further experiments may be expected which will show how these possibilities may best be realized. A successful demonstration in one or two communities now would go far toward assuring the development of prepayment plans for nursing throughout the country.

RUTH HOULTON

A Mothers' Club in an Industrial Suburb

By ELIZABETH H. CASTNER, R.N.

A mothers' club with broad aims for community betterment is described by a staff nurse in Rockford, Illinois

Elizabeth H. Castner

OUR MOTHERS' CLUB was organized as a part of a generalized public health program in a shack-town district bordering on a busy manufacturing city. Most of the first homes were rough little two- or three-room shacks, some without floors, made from salvaged lumber from an abandoned army camp. As the years progressed and the families became larger, they outgrew the small homes and began to build larger ones. The people for the most part were very poor and at the present time are on relief or employed by the Works Progress Administration. The population is made up of Belgians, Swedes, Finns, Italians, Lithuanians, Poles, and Americans. There is a predominance of Americans.

The class was organized by making a house-to-house canvass to locate prospective mothers and ask them to enroll. Ten mothers were willing to come but on the first day only two appeared. The only meeting place available was a church basement heated by a cook stove. The water froze in the bucket, and our faces burned while our backs were cold. In spite of these difficulties the class grew from the original two to twelve, by the time the nine maternity classes were completed.

A prize, which was given to the mother who could answer the most questions correctly in the quiz, was won by a young Negro mother and exhibited proudly to all her friends. This did a great deal toward getting members for a new class. Two complete courses of lessons were held in this basement and then the club moved into our present home, a small but very complete settlement house sponsored by the Junior League of Rockford.

At this time the original groups and a few other interested mothers decided to organize a permanent club and meet twice a month, with an enlarged program. The leader of the discussions was the nurse in the district. The topics for discussion were variations of the basic theme—health. After a year officers were elected in order to stimulate the group to further unity. New rules were made:

1. The president was not to succeed herself in office, so that more people might have the opportunity to serve.

2. The vice-president was to be the nurse in the district, so that the group would have a leader at all times.

3. The following standing committees were to be appointed by the president:
   - Committee for visiting the sick
   - Loan closet committee
   - Publicity committee
   - Clean-up committee
   - Program and social committee

4. The members were to take the course in home hygiene and care of the sick sponsored by the American Red Cross as a prerequisite to joining the club. Certificates from the Red Cross course given in other communities were to be accepted for membership.

The home hygiene course is taught by the nurse outside of regular club hours, and in four years 60 women have taken the course and joined the club.

The first meeting of the month is a business session, and the second has a program on some educational subject. Speakers have presented papers on tuberculosis, mental hygiene, and nutrition; and health movies from the State Department of Public Health have been shown. The children of members are cared for by a neighborhood girl who is paid by the club.

A rummage sale is sponsored every three months. The clothing is given to the club by the Junior League members. It is sold for a very small amount, and the money put into the treasury.

The club is a member of the Country Gentlewomen's League, from which it obtains many helpful suggestions for programs and new ways of conducting meetings. It also has the privilege of competing in the League's contests.

Three years ago the club felt a dramatic urge, and a small play was put on in the schools in the district. Much to the surprise of the members, the attendance was very large and they were asked to present another play. The casts of these two plays were all women; but this year eight of the husbands were induced to join the cast and they really had a good time. The men are now asking for another play and talking of organizing a fathers' club.

The mothers' club stands behind anything for the betterment of the district. A real campaign issue was made out of obtaining a piece of ground for a public park in front of the settlement house—and was won. The street commissioner was approached about fixing a hollow in the road which filled up with water in the spring and made the road impassable. The club sponsors a loan closet, where bedpans, thermometers, hypodermic syringes, towels, sheets, and pillowcases may be borrowed for use in the sickroom. Other achievements are the giving of $100 to the Rockford Visiting Nurses Association to endow a day in perpetuity; the purchase of two gross of tooth brushes and tooth paste for needy school children; and the purchase of crutches for a crippled boy.

Some of the benefits derived from such a club in any district may be summarized as follows:

1. A greater amount of teaching may be done in less time than is possible through individual teaching in the homes. This reduces the cost to the organization.
2. The mothers are able to give more intelligent care to their families in time of illness.
3. It promotes community interest and unity.
4. It affords the mothers needed enjoyment and relaxation away from home.
5. It promotes mental development.

The amount of work and the time consumed sometimes seem endless. But we really feel that we are accomplishing our objectives when we find patients going to doctors early in pregnancy, being prepared for home deliveries, and talking intelligently about yearly health examinations, preschool round-ups, quarantine, isolation, and immunization.

Three young mothers

Supervisory Experience for Staff Nurses

By MABLE E. GROVER, R.N.

Various methods by which staff nurses are given experience in assuming supervisory responsibilities are described here by a supervisor in an urban organization

IN ONE SENSE the preparation for supervision in public health nursing has no specific beginning. It is merely a continuation of that general preparation which constitutes the daily growth of the nurse. Dr. C.-E. A. Winslow has said that supervision is simply the sympathetic guidance and help which one gives to the people for whom one is responsible.

What are health organizations doing to prepare their staffs for supervision? Almost every day we hear of supervisory positions that are not being filled simply because there is a shortage of well trained personnel. Many times necessity demands that certain positions be filled without too long a waiting period, with the result that these key positions are given to nurses who lack a good basic general and professional education and a well rounded field experience.

The careful selection of the new staff is the first and the strongest link in the whole chain of careful preparation for supervision. An effective screening process is therefore of the greatest importance. It is a waste of an organization's time and money to spend weeks in giving a staff member intensive training only to find her unsuited for the work or perhaps physically incapable of carrying out the duties that will be assigned to her.

As a first step in a screening process many public health organizations are raising their entrance requirements. Many ask that every new staff member, in addition to being a graduate of a recognized school of nursing, have both theory and practice in communicable disease and psychiatry. Organizations also contemplate giving preference to those applicants who are graduates of a school of nursing in which a public health nurse is a member of the regular faculty—a provision which indicates that the effort has been made to integrate health into the entire basic education.

EXCHANGE OF NURSES STIMULATING

There is much of mutual benefit to be gained from the exchange of supervisors between hospitals and public health organizations. Stimulating also is the plan of bringing into the organization staff members and supervisors from other public health organizations either in an exchange program or for permanent placement. This exchange pattern should be worked out carefully between organizations which require the same high standards for their staffs. We are prone to think that our supervisors must have grown up with us. It is true they should have had well supervised staff experience with a good organization, and should have spent sufficient time with an organization to know its program before receiving a permanent supervisory appointment; but the wider their experience has been the more valuable they will be. Many details will, of course, have to be considered in working out such a plan, but the added stimulation and interest created by this direct

exchange of personnel more than makes up for the effort involved.

ROTATION THROUGH SERVICES

One way to contribute to the preparation of the staff is to rotate the nurses through the various activities and services in a center as much as possible. In this way the staff will learn to know the many little details that enter into the smooth running of an office. Take for example the simple matter of office housekeeping. Some individuals will always take it for granted that things arrange themselves and keep themselves in good order. Office order is not the responsibility of the supervisor alone but of every person in the office. Then there is the matter of keeping the literature up to date and of looking after the cupboards, boxes, and bags.

If each worker is to appreciate the teaching and supervision that goes on in clubs and classes, it is absolutely essential that all the staff members be rotated through such services as mothers' clubs, preschool clinics, and child guidance classes. It is as the nurse becomes better acquainted with all these various interests that she discovers her own needs in theory, in practice, or in both. When she asks for assistance we should be prepared to help her make plans on an individual basis.

There are various ways of preparing the staff for supervisory responsibilities, and each agency will have to experiment with the methods best adjusted to its size and budget, making a careful objective evaluation of successes and failures. In the Henry Street Visiting Nurse Service, two special plans have been tried out experimentally. We call them senior staff experience and senior advisory experience.

SENIOR STAFF EXPERIENCE

The first plan, called senior staff experience, grew out of a desire on the part of the staff for more experience in supervision. They said in effect: "We are not only looking for new fields but we are particularly anxious to make our own work more productive. We are anxious to know more about the responsibilities of a supervisor, and her methods of introducing new staff members to the field. We should like to participate intimately in this whole supervisory work in order to benefit by the guidance and direction of those seasoned with experience." This was a most natural interest. The aims of this new experience for the senior staff nurses were then set up as follows:

1. To give an opportunity to the participating senior staff nurses for further individual development.
2. To see whether supervision is the type of work the nurse would like to do and whether she is fitted for this particular kind of work.
3. To give preliminary preparation for the supervisory field in public health nursing.

A senior staff nurse was selected on the basis of the following qualifications:

1. She must have been on the staff not less than two years except in an exceptional case where the qualifications were unusually high.
2. She must have done exceptionally good staff work.
3. She must have the ability to get along with people.
4. She must have given definite evidence of teaching ability.
5. She must have a thorough knowledge of the district.
6. She must have completed the fundamental courses in public health nursing including:
   - Public health nursing
   - Social case work
   - Psychology
   - Principles of teaching.

   Additional courses suggested were:
   - Principles of teaching in public health
   - Nutrition
   - Sociology.
7. She must have definite plans to continue with a course in supervision at a recognized college or university concurrent with or very soon after the senior staff field work.

Exceptions to any of the above rules were to be discussed with the educational director.

Because many more requests were received from the staff than could be taken care of, the selection of the nurses for this special experience was made only after a very careful consideration of all the foregoing qualifications by the local supervisor and the educational director. This special four-months' experience was always planned for in the centers where there were students, since the nurse's supervisory practice was with students rather than with the staff nurses.

PLANNING TOGETHER FOR STUDENTS

Since all of the undergraduate students come on a two-months' basis, the senior staff experience divided itself naturally into two periods each of which was two months in length. The first two months served as an introductory period. Since the organization considered that it could allow only part time for senior staff experience, the senior nurse was expected to spend approximately half of her time in the field. She either carried a light district without a heavy bedside load or acted in the capacity of a "floater," helping wherever she was needed. Her half day as senior staff nurse was used in conferences with the supervisor or in observation of the supervisor's activities with the students.

Before the students arrived, the supervisor and the senior staff nurse together prepared the office for them. The contents of their bags were gone over carefully; boxes were prepared for their records; and any other special needs were anticipated. The seating arrangement was considered important. Where it could be managed without confusion for the staff it seemed ideal to place a student next to an experienced staff member so that each would benefit from the other's experience. It was helpful for the supervisor to review with her senior nurse the credentials of the students in order to know them more intimately from the outset. The supervisor also gave her senior nurse special instruction in keeping the students' daily experience sheets and the field supervisory reports. She explained the importance and method of the individual conference with the student after field supervision, and of any other conferences that seemed indicated.

The supervisor conducted all the special group conferences the first two months. The senior staff member participated in the discussions, took notes, and made plans for her own conferences which she would give the last two months. She was expected to write up her material as soon as possible after listening to the supervisor's discussion. Some office time was allowed for the writing of these conferences, but the nurse was always expected to give some of her own time in preparation. Besides the duties mentioned the senior staff nurse would assist the supervisor to:

1. Plan for the student's observation in the field and in the various special clinics.
2. Plan the weekly program of the senior staff nurse. (A special time was set aside for this.)
3. Plan for the supervision of students in the field and assist with it. The senior staff nurse would prepare a report of her supervisory visits with the student and conduct a conference with the student following the visits.

During the second two months the senior staff nurse was given much more responsibility for these activities, with participation as needed by the supervisor.

After each of the group conferences conducted by the senior nurse the supervisor went over with her the material she had presented, her method of presentation, and the group discussions.

A conference was also held between the senior staff nurse and the supervisor after each of the former's field supervisory visits with the student. This conference was for the purpose of discussing the method of writing the supervisory report and the evaluation of the student's visit. The type of reports that

the senior staff nurse would write might be either a form report or a narrative account. The latter was more difficult to write but frequently more enlightening. At the end of the two-months' period the senior staff nurse and the supervisor each wrote a final report of the student's work. A composite picture of the two reports was made to show the student's activities, her special interests, and her strong and her weak points. The supervisor discussed this final report with each student.

During the four-months' senior staff experience, three special group conferences were held between the senior staff nurses and the educational director. The first was of an introductory nature when general plans for the entire period of experience were outlined. The second was held at the end of the first two months. At this time the senior nurses' experiences to date were discussed in full and the outlines of conferences prepared by the senior staff nurses were carefully reviewed. The local supervisor and educational director met to discuss any special problems at this halfwav mark. Then, at the end of their four-months' experience, the senior group had a final review with the educational director. The purpose of this last conference was to make an objective analysis of their whole experience, giving any suggestions that might be helpful to the incoming group of senior staff nurses.

The local supervisor wrote two reports on her senior staff nurse during this period, one at the end of her first two months and one at the completion of the fourth. Both these reports were read by the senior staff nurse and discussed in detail with her before they were sent to the educational director. Each senior staff nurse also kept a daily work sheet during this whole period in order to furnish a complete picture of her various activities. All this material was filed with the senior staff nurse's personal records for future reference.

Every one who participated found the program exceedingly valuable. In a few cases the senior staff nurses found to their surprise that they were not suited for supervisory work, but they knew they were better staff nurses for having had the experience. No wonder the waiting list was long!

From the time this service was inaugurated in October 1934 until the end of 1937, 43 senior staff nurses had the four-months' experience. Out of this number, 12 have since become supervisors and 2 assistant supervisors with the organization. Most of the others have either taken supervisory positions with other public health organizations or have gone on to college for postgraduate study. A few have gone back to the regular staff. We have no figures available to show the actual cost of this service, but measured in terms of the value gained in supervisory material it would not seem too costly. The greatest disadvantage came from the fact that only a small number could be withdrawn from the field at any time, and the list of those who asked for the experience grew longer and longer. The plan was therefore discontinued in an effort to devise a program which would spread the advantages among a much larger group.

SENIOR ADVISORY EXPERIENCE

The second method adopted is a modification of the one just described. It follows the same general plan, the chief difference being that it attempts to give opportunity for growth and advancement to a much larger number.

In general the objectives in our senior advisory program are the same as those set up for the senior staff program, except that by this plan we aim:

1. To give each of a large number of well qualified senior staff nurses the privilege of guiding and directing a student or new staff nurse into the field of public health nursing under careful supervision.

2. To give the senior nurse the advantage of learning from her student the latest developments in medicine, with which the student is familiar through her recent or current hospital experience.

3. To give the senior nurse a more direct contact with the school of nursing in order that she may become better acquainted with the whole program of nursing education.

In the selection of staff nurses as senior advisers our requirements have been modified. We are letting nurses with less exact preparation have this experience, hoping that the staff will be stimulated toward greater self-improvement. The choice of a staff nurse for senior advisory experience does not in any way presuppose that she is interested in supervision as a career, or that we have her particularly in mind for supervisory work. But we are careful to select only those staff members who are alert, interested, and progressive in their work and in their thinking. More than that we are selecting those who have had:

1. Sufficient experience with the organization to interpret its policies accurately.

2. Sufficient experience or theoretical preparation to interpret the modern public health program.

3. A real interest in sharing their skill and knowledge in the development of new or potential public health nursing personnel.

In this plan each student and new staff nurse is assigned to a carefully selected senior advisory nurse for immediate guidance. Under the direction of her supervisor the senior adviser is responsible for planning a graduated, well rounded experience for the student, for interpretation and guidance in its performance, and for evaluation of its progress and results.

In this program the supervisor is directly responsible for guiding and directing the senior adviser. She does this by means of individual and group conferences such as those described in the first plan. The individual conferences are held with the adviser weekly to discuss the progress of the student and to plan her future work. The group conferences include a general discussion of the whole plan of the senior advisory program, stressing its value to the adviser and the student and the specific methods by which it is carried out.

The local supervisor is responsible for conducting all the local group conferences for the new staff and students. The senior advisers attend a series of these conferences in order to be thoroughly familiar with the material presented. There is a constant interchange of ideas between the student, the senior adviser, and the supervisor in order that the best possible program may result.

EVALUATION OF PLAN

To assist in evaluating this whole plan the senior adviser keeps a careful record of her experiences on a daily work sheet. The supervisor also writes a report on the adviser's work at the end of every student's experience—that is, every two months. If the work seems to be satisfactory these progress reports may be made less frequently after the first four months. The senior adviser reads and discusses with the supervisor the report of her work, before it is sent to the educational director. The nurse is encouraged to evaluate her entire experience carefully and make any suggestions for improving the plan.

Just as the senior adviser with the help of the supervisor is responsible for introducing new staff and students to the field, and the supervisor in turn is responsible for guiding and directing the senior adviser, so the educational director is responsible for guiding and assisting the supervisor in planning an educational program for the staff.

It is too early to predict the results of this plan in our organization. However, if discussion and keen interest are any indication, there will be much healthy competition for the privilege of working with the students. This program allows participation of a group of fifty at one

time, whereas the senior staff program gave experience to only a few—from four to six at a time. The staff has already been stimulated to a noticeable degree and it is hoped and believed that the plan will do a great deal for staff development.

Presented before the Round Table for Supervisors of Urban Agencies, Biennial Convention, Kansas City, Missouri, April 17, 1938.

How Would You Answer This?

What is the best technique for doing the perineal dressing during the postpartum period?

In reply to this question published in the December 1938 issue and answered by the Maternity Center Association in the January issue, we have also received the following description of a technique for doing the perineal dressing. The Maternity Center Association, 1 East 57 Street, New York, N. Y., will be glad to receive your questions and problems in maternity nursing. Those of general interest to our readers will be published in this column.

Scrub the hands thoroughly for three minutes under running water with tincture of green soap, using a brush. Wipe the hands dry. Place a clean paper towel on the bedside table or a chair which has already been protected with newspapers. On the towel place six or more large pledgets of cotton, a vulva pad, a bottle of tincture of green soap, and a pitcher of tap water (body temperature). Protect the bed with newspapers. Place the patient on a bedpan which has been previously heated, and drape her. Place a paper bag in front of the bedpan.

Scrub the hands again for three minutes under running water with tincture of green soap, using a brush. This time do not wipe the hands dry. Keep them surgically clean, and avoid dripping from the unscrubbed part of the arm on to the clean area.

Apply tincture of green soap to one pledget of cotton. Cleanse the outer parts of the vulva without separating the labia, always using a downward stroke. Repeat this procedure from three to four times as needed. Then pour water down over the perineum, without separating the labia. Take dry pledgets of cotton and wipe the patient dry, using a downward stroke. Remove the patient from the bedpan. Apply the vulva pad. If sutures are present, cotton and clear, freshly boiled water are used.

This procedure has been in use for the past fourteen years without the occurrence of complications or infections.

LUCY R. FOLEY, R.N.
District Nurse Association, Middletown, Connecticut

Industrial Nursing—Past, Present, Future

By MELVIN N. NEWQUIST, M.D.

A physician who has studied industrial health services as a representative of the American College of Surgeons discusses the functions of the nurse in industry

IN THE EARLIER days of industry, very few women worked in the industrial plants and a female graduate nurse in the plow works was not only considered a useless extravagance but a veritable encroachment upon a man's world. Frequently an employee who had developed a shop reputation for being adept at removing foreign bodies from the eye with a horsehair loop or a jackknife would be called upon to perform other nursing and doctoring duties in the plant. Not infrequently the distinction of being the "handy man" at times of industrial injury or illness would accrue to a worker who had tried out his home remedies on his large and growing family and was ever ready to foist his cures on his fellow workers. If such helpers were not available it would devolve upon the foreman or the plant superintendent to be the Good Samaritan. Of course, a physician would always be called when an accident caused a serious injury or gave rise to sufficient excitement.

In the early days, visiting nurse service as we now know it was nonexistent. Visits from the plant to the home of an ill or injured employee were made by fellow workers or possibly the superintendent, who would tender flowers and sympathy to the potential widow and occasionally financial assistance as a result of "passing the hat."

Infections, complications, and disabilities following industrial injuries were so frequent and so vexatious that some of the pioneer employers were forced to introduce corrective measures in their plants, to employ better qualified first-aid attendants, and to change doctors at times. As time went by industry became more and more mechanized and women were employed in increasing numbers. In the period from 1870 to 1930 the gainfully employed male workers in the United States increased only 12 percent while the female workers increased approximately 85 percent*. Gradually the female graduate nurse clad in her spotless uniform filtered into industry. As was to be expected the brass cuspidors began to disappear from the first-aid rooms, and a state of cleanliness in the dispensaries replaced their former appearance of bachelor quarters.

It required, however, the introduction of the workmen's compensation laws and the launching of the safety movement in which the National Safety Council has played the leading role to give industrial nursing the stimulus and the opportunity which it deserved. Faced with the immediate costs of disability arising from industrial injury, actual and alleged, employers introduced pre-employment physical examinations as a protective measure, established more first-aid rooms, and employed additional first-aid attendants. The full-time services of first-aid attendants became a necessity now that injured employees were being required to report promptly to the first-aid room for treatment regardless of how trivial the injury.

Lay first-aid attendants predominated

*U. S. Department of Commerce, Bureau of Census. Manufacturers. Washington, D. C., 1929.

at first. But it was gradually demonstrated that the superior training of the graduate nurse; her knowledge of sepsis and asepsis, of illness and injury, of first-aid technique and the limitations of first aid, and of record keeping made her employment not only advisable but profitable. Her ability to handle people and finally her uniform proved to be of additional psychic value.

During the past several years it has been my privilege to visit medical services in industry throughout all parts of this country, as a representative of the American College of Surgeons. An opportunity has thus been afforded me to see the conditions under which nursing service in industry is conducted and to evaluate the character of the service rendered by the nurses.

It was soon evident that there was a lack of uniformity in the character and scope of the nursing service in different plants. In some places nurses are being called upon to assume responsibilities which should not be assigned to them; in other places they do not grasp their full opportunities for service. Responsibility for this condition is not to be attributed entirely to the nurses themselves, for in most instances their sphere of activity has not been defined for them.

As a result of this experience it would seem useful to attempt to formulate a statement which will describe as accurately as possible the present and future status of industrial nursing.

PLACE OF THE NURSING SERVICE

The nursing service in an industrial organization is a part of the health service and not all of it. A properly organized health service should have a qualified physician at its head and all health activities should be supervised by him. The nurse in industry should coöperate with the plant physician, the safety engineer, and the manager of industrial relations; but she should not replace them. Overenthusiastic individuals have promulgated nursing programs so complicated and extensive that it would seem the physician and the safety engineer were no longer needed. It should be emphasized that there is ample opportunity for rendering constructive service within the legitimate field of industrial nursing and furthermore that the ultimate goal is more quickly and efficiently accomplished through teamwork—or coöperative interdepartmental working relationships.

So much of the first-aid service in a plant overlaps what is actually medical service that it is impossible to separate the two. Therefore, medical supervision of the entire first aid, nursing, and medical service is indicated. Anyone may render first aid in emergencies. But when a service is established in a plant to treat ill and injured workers who are not only expected but required to report to the first-aid station, a different light is thrown upon the situation. Furthermore, redressings under such conditions cease to be first aid. They become the practice of medicine. An employee who is given a dose of Epsom salts for abdominal distress by the first-aid attendant may suffer a ruptured appendix with peritonitis, and may present the first-aid attendant and the employer with a lawsuit for malpractice—to which may be added one for practicing medicine without a license. Such legal complications are not infrequent.

Physicians should formulate and sign general standing orders for the first-aid and medical service in the plants which they serve and they should follow this up by periodic visits to the plant in order to make the intended supervision effective. A change of plant physician requires standing orders signed by the new doctor. Nurses have frequently refused to assume their duties in the plant until the above supervision and protection were provided. Many leaders in the medical and nursing fields, and organizations such as the National

Organization for Public Health Nursing have repeatedly stressed this point.

The sole purpose of requiring adequate medical supervision of first-aid services is to protect ill or injured workers from being treated by incompetent or unqualified persons. In this connection specific provision has recently been made in the New York Workmen's Compensation Law to the effect that laboratories and bureaus, including first-aid departments in industrial establishments which participate in the diagnosis or treatment of injured workmen, shall have medical supervision. Similar coverage exists in all states in their respective medical practice acts. In most instances physicians are willing to render this supervisory service to the plants which they serve without additional expense to the employer.

FUNCTIONS WITHIN THE PLANT

It is presumed that the nurse will visit the various plant departments early in her assignment in order to familiarize herself in a general way with working conditions and hazards. Thereafter, the indicated present-day duties of an industrial nurse are as follows:

1. To assist the physician in making preemployment and periodic physical examinations. These examinations are not to be made by the nurse or the lay first-aid attendant.

2. To render first-aid and subsequent care of industrial injuries and occupational disease as directed by the physician in charge. In most manufacturing plants this is still the most important function of the nurse and the reason for her employment.

The suturing of lacerations, the anesthetizing of eyes in order to remove foreign bodies imbedded in the cornea, and other similar procedures are still being done by lay first-aid attendants but seldom by nurses. The nurse knows her limitations. Obviously such unsafe practices should be discontinued.

3. To render reasonable first aid and advice to employees suffering from nonindustrial injuries and illnesses while on duty, according to the policies and standing orders for such service. For further professional service, employees suffering from such conditions should be referred to their private physicians.

Here again the nurse can and does play an important role. Many of the workers who come to the dispensary—particularly women—may not see the doctor. The nurse who is alert, however, recognizes the cases that may become more seriously ill and she refers them to the plant physician for examination and advice or directly to the family physician.

4. To coöperate with the safety department by:

a. Reiterating safety principles to employees at the time of dispensary visits.

b. Explaining and emphasizing to employees the program in plant sanitation when indicated.

c. Reporting all accidental injuries and occupational diseases that should be investigated from the standpoint of casual relationship and prevention.

d. Reporting to the physician for examination, and also to the safety director, those employees who are accident repeaters or who seem to be prone to accidents on account of mental or physical defects.

5. To coöperate in developing an acceptable program in health preservation and health education by:

a. Giving appropriate advice to individual employees.

b. Giving talks to groups on appropriate nursing subjects.

c. Distributing literature on health subjects.

d. Encouraging workers to have periodic physical examinations where such examinations are not already being made.

e. Assisting in developing adequate recreational programs and facilities.

f. Assisting in maintaining certain phases of the sanitation program by inspecting the plant cafeteria and kitchen, and the women's toilets and lockers.

g. Coöperating with private physicians and with local and state health and welfare agencies in activities designed to benefit the health of the worker and the community as a whole.

6. To keep adequate records by:

a. Recording all industrial injuries and occupational diseases.

b. Recording all employee visits to the dispensary for nonindustrial injuries and illnesses.

c. Maintaining physical examination records as confidential information. It is presumed that the physician is responsible for the completeness of such records.

d. Compiling statistical summaries of the injury and illness experience at intervals and reporting them to the indicated officials. Such studies will serve to indicate future objectives of the service.

e. Computing or obtaining annually the frequency and severity rate of injuries. These rates are not only an index of the efficiency of the safety service but also of the medical and nursing or first-aid service.

FUNCTIONS OUTSIDE OF THE PLANT

After the health service has been well organized within the plant the opportunity of providing a worth-while nursing service outside of the plant should not be overlooked. Visiting nurse service can and will reduce absenteeism. How? First, it will reduce the actual sickness disability by arranging for more prompt and adequate medical, hospital, or nursing service. Second, which is a concomitant result, it will reduce absenteeism due to unnecessary personal reasons.

When visits are made to the homes of ill or injured employees they should be made in the spirit of helpfulness, never for the purpose of espionage. The nurse may find the absent worker badly in need of medical or hospital care. Whether ignorance or poverty has caused the delay she tactfully and promptly arranges for such service through the family physician if possible, or if necessary through local health and welfare agencies. Possibly some nursing care is all that is needed. In such instances she not only renders this service at the time but—of greater importance—she teaches some member of the household how to continue the care, how to prepare nourishment, or how to prevent the spread of the disease. The nurse can be of aid in correcting personal and social maladjustments. And finally, by spreading cheer and giving encouragement and reassurance she will not only be a helpful psychotherapist but will also serve as a perpetual ambassador of good will.

While the plant nurse may make occasional home visits, providing the service in the plant is adequately covered during her absence, this service is best rendered by nurses who are specifically assigned to such duties. Visiting nurses may be employed by the industrial organization; or such service may be provided through the employees' mutual aid association, through the carrier of the group insurance, or through local public health nursing associations. It is needless to say that the visiting nurse service should be closely correlated with the health service in the plant in order to obtain the greatest benefits.

FUTURE OF INDUSTRIAL NURSING

The number of graduate nurses in the field of industrial nursing has not yet reached the saturation point. Their performance in industry has been so commendable and valuable in the past that their employment in greater number in the future is assured. While employers will continue to select their nurses on the basis of general nursing qualifications, character, appearance, personality, and administrative ability, they will also inquire as to their special training which is applicable to this field.

Notwithstanding the fact that better prepared nurses are being graduated each year, the formulation and promulgation of standards for industrial nursing will serve as a guide for schools of nursing in arranging their curricula and will provide a stimulus for growth and greater accomplishment in this particular field of endeavor. Applicants who contemplate going into industrial nursing will find that in addition to the preliminary academic training required for entrance to a school of nursing, a knowledge of typewriting acquired in high school will later prove to be an asset in their industrial work. For industrial purposes it is highly desirable that the nursing curricula provide for: instruction and experience in caring for both men and women; opportunity for learning nursing techniques in the surgical

department; experience in the outpatient department and particularly in the emergency department of the hospital where instruction in first aid is given; some experience in public health nursing.

The student nurse in the past has been informed as to the role played by bacteria and trauma as causes of disease. It is hoped that the nurse of the future will also have a working knowledge of occupational disease and of the broad subject of mental hygiene. Industrial nurses should be registered in the states in which they are employed. They should continue to increase their knowledge by keeping abreast of scientific literature applicable to this field and by attendance and active participation at professional meetings of nursing groups.

With the elevation in standards for industrial nursing, however, we should not lose sight of the fact that the worker is a human being and as such he should receive individual consideration and kindly treatment—not paternalism. Industrial nurses should continuously strive to inculcate in the minds of the workers a desire to work safely, to maintain their greatest asset—health; and to render a life of useful service. If this is done it cannot be said that industrial nursing has lost its art and that it has wandered too far from home.

Presented before the Section on Industrial Nursing, National Safety Congress, Chicago, Illinois, October 13, 1938.

The "Attendant Nurse" in the Home

By LILLIE YOUNG, R.N.

A Vermont community prepares nursing attendants for the care of the sick in the home and supervises them through its visiting nurse association

THE PROGRAM for the training and use of attendant nurses in the homes in our community grew out of the needs of the people. At the time the plan was initiated, 31 years ago, there were few graduate nurses available in the town. The school of nursing in the local hospital was then in its infancy and its few graduates were needed to care for patients who were very ill. However, the hospital did provide a graduate nurse to do visiting nursing, and one of her early reports states that the people did not have adequate nursing care in the home. During the hours intervening between her daily visits someone was needed to care for the patient and look after the family. For example, a mother who was ill required continuous nursing care for herself and provision for the care of her children. Someone was needed to see that the family had their meals and that the children were not on the street, and to perform the many other duties needed to keep the home running smoothly.

A small group of women from the local churches formed an organization to survey the town and find women helpers who were willing to do just these things in the home. For a time the organization, which is called the Brattleboro Mutual Aid Association, used the secretary's home as a service office in which to receive calls and have interviews both with those who wished to do the work and those who needed to have the work

done. Later a graduate nurse was employed to supervise these helpers. She also acted as maternity nurse, giving antepartum and postpartum service and assisting the physicians with confinements in the homes. The helpers, of which there were only three or four in the first five years, were placed on salary, and the nursing instruction was given in the homes where they were working. In homes where the supervisor attended the birth of the baby and gave the first postpartum care, the helpers gave continued nursing care and in addition were very useful in keeping the home running smoothly. Much of their work was also in the homes of mildly ill and chronic patients.

COURSE OF INSTRUCTION STARTED

Later it was decided to give systematic, consistent instruction to these women. In 1917 the course of training which is now known as the Thompson School for Training Attendant Nurses was organized. The directors of the school planned the instruction on the basis of service that was needed in the homes. For that reason it was deemed unwise to give all or the major part of the training in a hospital.

The course at the present time is fifteen months in length. It consists of two months of household duties, with class work in dietetics and practical nursing; six months of practice in a general hospital; and seven months in maternity service and the care of the sick in their homes. The training school operates in close coördination with the Association and a member of the nursing staff teaches the practical nursing classes. The supervision and guidance of work in the homes are always given by one of the four public health nurses on the staff of the Brattleboro Mutual Aid Association.

The applicant who enters the training school must be at least twenty years of age. She may have had only grammar-school education, or she may be a high-school graduate. Before they come to the school for training, these women have been housekeepers, mothers of families, stenographers, school teachers, housemaids, or clerks. Probably one reason there is no difficulty in placing the attendant nurse in the home is that she is fitted for home nursing by her previous experience coupled with the instruction she receives. On the other hand, a graduate nurse who has entered the school of nursing as soon as she finished high school has been surrounded during three years with hospital atmosphere where every duty was closely supervised. Because this nurse is still quite young, she has difficulty in adjusting herself to nursing in the home, especially where modern conveniences are lacking. And she finds chronic, mildly ill cases rather uninteresting.

After the attendant nurses are graduated from the course and go out from the service office on cases, they are still supervised. This supervision not only assures that they do not overstep in regard to the nursing procedures which they had been taught, but also makes sure that the families do not impose upon them. There are instances where people expect them to do the family washing, and to be up during all hours of the night.

Our community and the surrounding territory over a radius of from 30 to 40 miles has a population of perhaps forty thousand people. In the area surrounding Brattleboro it is very often a public health nurse who calls for the attendant nurse to help in the home where sickness is present, and the public health nurse thus acts as supervisor while the attendant is in her district.

These women are found to be conscientious in following out the doctor's orders for the patient and also very desirous of pleasing the family. They welcome the graduate nurse who will act as a friend and adviser when necessary.

Other duties which they perform in

the home besides the general nursing care of the patient vary according to the needs. The attendant nurse does not do the family washing, ironing, or general housecleaning. She is not expected to bake bread, pies, and cakes, but she does the ordinary cooking for the patient and where necessary, assists with the family meals. She keeps the home running as nearly normal as possible with a sick person to care for.

NURSING INSURANCE PLAN

There was a time when the economic status of a family rather than the type of illness was the basis for decision as to whether they requested an attendant nurse or a graduate nurse. Now, we have a plan of nursing insurance available to all the people of the community, and the doctor has no hesitancy in saying which type of nurse is needed. Calls for both graduate and attendant nurses are received day and night through the service office of the Association. The insured patient who needs a graduate nurse may have her services for approximately the same cost to him as that of an attendant nurse. The insurance makes up the difference.

The yearly benefit dues for nursing service are as follows:

Single men	$3.50
Single women	3.00
Married couples, one working	5.00
Children under 16	.75

For new members of advanced years higher rates are charged.

While the attendant nurses are still in training, they are sent to the homes at a charge of $15 a week. The first year after graduation the charge is $21 a week; after that it is $25. If the patient is insured he receives the services of an attendant nurse at half of the usual rate, or the services of a full-time graduate nurse at one third of the usual charge.

NOTE: An article by Leora B. Stroup on the training of subsidiary workers in Detroit, Michigan, will appear in the April issue.

NURSE PLACEMENT SERVICE

placements in Public Health Nursing were approximately tripled in the past six months. Permission is being sought from both nurses and employers for publication of appointments made since the last report and the list will appear in a later issue.

Placements have been made in interesting situations in Connecticut, New York, Pennsylvania, Illinois, Iowa, New Mexico, and other states. Many nurses are now making their histories active, with a view to changing their locality in the autumn. The greatest need exists in the specialized fields of orthopedic nursing and maternity nursing, and there is every indication that the demand will continue to grow rather than to decrease. Nurses who have not had their professional records transferred from Joint Vocational Service may do so by addressing a request to the National Organization for Public Health Nursing, 50 West 50 Street, New York, N. Y.

Gleanings

Suggestions in regard to improvised equipment, methods of publicity, and new ideas that have proved practical are published in this column. Contributions are welcome.

AN OBSTETRIC PACKAGE FOR RURAL COMMUNITIES

ONE OF THE ACTIVITIES made possible through Social Security funds was the promotion of an obstetric package for use in rural communities. This package contains gauze and absorbent cotton dressings, cord ties and dressings, towels, leggings, perineal pads, delivery pads and bed protectors, and paper bags for waste. We have kept the cost of these materials as low as possible in order to promote the use of a greater number of packages. (We are, however, glad to have local organizations add sterilized rubber gloves and gowns, if they feel able to add that to the expense.)

Each of the state consultant nurses has a complete package for demonstration purposes. In addition, a miniature package is furnished to each organization making up the package. With the miniature package goes mimeographed instructions for making the package and mimeographed instructions for using the package after it is made.

It is our plan to have these packages introduced to local women's organizations by our consultant nurses and demonstrated by them. The local organizations, if interested, will then make up as many packages as they can afford, or as they deem necessary, for home deliveries in their communities. The packages are to be sterilized at local hospitals and kept at some convenient place that is open twenty-four hours of the day. This means that some are kept at fire departments, police headquarters, drug stores, or hospitals.

The packages are to be used by local physicians and nurses in home deliveries. They are to be resterilized after three months if they are not used. Some of the contents of the packages, such as leggings and towels, can be returned to the local organization, washed and resterilized, and used in other packages. This, of course, reduces the cost.

Some women's organizations provide these free; others charge amounts varying from seventy-five cents to five dollars for their use.

This project was started in November 1937, and there are now twelve communities using the package.

—From "Obstetric Package Project," by Florence L. McKay, M.D., *The Commonhealth* (Massachusetts), Jan.-Feb.-Mar., 1938, p. 47.

THE WELCOME WAGON

IN OCTOBER 1937 our organization went on The Welcome Wagon. This wagon, driven by a hostess, calls at the home of every newcomer in town. The hostess extends the greetings of the city and the merchants to the housewife. Frequently she leaves complimentary quarts of milk, loaves of bread, directories of special services, et cetera. The hostess now tells the newcomers and the brides about the services offered by the Visiting Nurse Association, and leaves our information bulletin. We understand this plan is available in cities wherever there is Welcome Wagon service.

RACHEL C. COLBY, R.N.
Nursing Director,
Visiting Nurse Association
of New Britain, Connecticut

The Nurse's Part in the Control of Cancer

By LOUIS C. KRESS, M.D.

Cancer of the skin, lips, mouth, and tongue are all amenable to early treatment, and the nurse has a responsibility for teaching the vital importance of prompt medical attention

Part II

CANCER of the skin consists of three large groups: (1) the basal cell type or rodent ulcer (2) the squamous cell (3) the melanoma, or pigmented malignancy of the skin. The first type, the basal cell epithelioma, grows slowly and rarely spreads to the regional lymph glands. (This process is called metastasis.) The basal cell type responds readily to treatment and seldom results in the death of the patient. The squamous cell epithelioma, which is sometimes referred to as the pearl cell, develops much more rapidly and requires more therapy for its complete destruction. It has a tendency to spread to the regional lymph nodes and if not influenced by adequate treatment has a tendency to result in the death of the patient. The melanoma is a pigmented skin nodule, usually black or bluish black, which should be destroyed as soon as it is discovered.

Etiology: Some form of chronic irritation is usually the underlying cause of skin cancer. Most skin malignancies are found on the uncovered portions of the patient's body. However, skin cancer may occur on any part of the skin surface. This type of cancer is found more often in men than in women due to the fact that men lead out-of-door lives because of their occupations and are thereby exposed to the elements such as heat, rain, snow, sleet, and wind. For instance, skin cancer, especially of the face and hands, is prevalent among farmers. Because a beautiful skin is an asset to a woman's beauty, she protects her skin. Perhaps if men would give the same protection to their skin, less skin cancer would occur.

Symptoms: A scaly spot called a keratosis may be the first indication of a skin cancer; or it may appear as a slight elevation in the skin, sometimes covered by a pearly white scale. This scale flakes off several times and finally forms an ulcer, which in turn is covered by a dark brown, red, or black scab. The scab forms and falls off two or three times and then a persistent ulcer results. If the patient does not heed these warnings and allows this ulceration to continue, large areas of skin may become involved and an avoidable form of cancer may claim another life.

MOLES AND BIRTHMARKS

Moles and birthmarks, or the skin melanomas (pigmented tumors), should receive some attention. The brown or tan mole is not dangerous unless it begins to grow, changing in size and shape; or unless it becomes raised, changes its color, and begins to bleed because of irritation from clothing. If any of these symptoms occurs, this growth should be removed. The small black mole or melanoma should be removed immediately wherever and whenever it is seen; for once it starts to grow it may dis-

seminate to every organ of the body, causing the death of the patient. The old saying, "An ounce of prevention is worth a pound of cure," is certainly applicable in the case of the black mole. If allowed to remain, this type of mole may lie dormant for a long time and then suddenly for unknown reasons begin to grow very rapidly.

A nurse in making her daily visits should observe her patients carefully for the appearance of cracks, sores, or fissures on the skin of the face which persist for a week or ten days, because such lesions should receive the prompt attention of the examining physician. By directing these potential cancer victims through the proper channels for medical care, a nurse can be of significant aid in the prevention or cure of cancer in her patients.

Cancer of the skin which involves the corners of the mouth, the alæ of the nose, and the inner or outer canthus of the eye does not respond so readily to treatment as do skin malignancies situated elsewhere. Biopsy is often performed in order to make an accurate diagnosis, and the nurse should recommend this procedure to the patient if the physician or surgeon suggests it.

Treatment: The treatment for these types of skin cancer is varied. Surgery, radium, x-ray, electrocoagulation, and cautery are used with excellent results. Successful destruction of the lesion depends not so much on the type of treatment used as on the thoroughness of that treatment. In other words the entire lesion must be destroyed. Otherwise, the growth will recur. If the regional nodes are involved, these too must receive attention so that the cancer cells in them may be killed.

Prognosis: Approximately 95 percent of all skin cancers are curable. Advanced cancer of the skin is the result of neglect or ignorance on the part of the patient in regard to the symptoms and treatment of this disease. The nurse should encourage the patient to secure proper medical attention for any symptom of skin cancer which may arise.

CANCER OF THE LIP

Cancer of the lip is similar to cancer of the skin in that lesions of the lip can be seen by the patients and their friends almost from the very beginning. However, many people suffering from cancer of the lip see a physician when the disease has progressed to an advanced stage and the chances of cure are lessened. If treated early, cancer of the lip responds quite well to therapy. Again the nurse can be a potent factor in suggesting prompt medical advice or if necessary making provision for the patient to receive such attention.

Etiology: Certain forms of chronic irritation such as dry, scaly lips, persistent cracks and fissures of the lower lip and corners of the mouth, the hot pipe stem, and the combustion products of tobacco are often associated with this disease. This, of course, does not mean that one should refrain from smoking unless the tissues of the lip cannot withstand such chronic irritation—which will be evidenced by either a raised, whitish area called a leukoplacia, a tiny wart or scaly growth, or a small ulceration. This type of cancer occurs more frequently in men than in women because the latter give their lips more care. Few women will allow a crack, sore, or fissure to exist, especially where it can be seen, because it detracts from their beauty. If men would assume this same attitude, less cancer of the lip would occur.

Symptoms: There is no pain associated with early cancer of the lip. In the beginning it is a local lesion confined to the lip, occurring usually on either side of the midline and occasionally in the midportion. If it has existed for some time, it may gain access to the lymph stream and cause metastasis or enlargement of the lymph nodes beneath the lower jaw and under the chin, known

as the submaxillary and submental regions. As the lesion develops, it spreads both laterally and medially as well as toward the inner and outer surfaces of the lip. The ulceration is persistent, and the growth may have rolled edges with an indurated base or it may be the hyperplastic type which grows away from the patient's lip and ulcerates later.

Treatment: Here too as in skin cancer various types of therapy are employed, and all are efficacious if thorough enough to destroy the entire growth. Removal of the growth together with the adjacent normal tissue, and dissection of the glands of the neck are still practiced in some clinics. Others treat both the primary lesion and the metastases with radium and x-ray. Electrocoagulation is also used to eradicate the cancer, and at times the metastases are treated with radium in diverse forms. Different techniques are followed.

Prognosis: In the early local lesions the results are gratifying, but after metastasis has occurred, they are not as good. Therefore, it behooves every nurse whenever she sees or is consulted about a persistent crack, sore, or fissure involving the skin, lip, or mouth to insist that it receive the attention of a physician immediately. Delay may be dangerous and quick action is very important for the patient.

CANCER OF MOUTH AND TONGUE

Cancer is a preventable disease, and an excellent example of this fact is found in cancer of the mouth. Rarely is cancer of the mouth seen in a patient who has maintained good oral hygiene. This implies the correction or removal of any ragged or jagged teeth, impacted teeth, retained roots, and ill-fitting dentures. These conditions are sources of chronic irritation; and if they are corrected or prevented, cancer is not so apt to occur. The best way to practice good oral hygiene is to have a dental examination and necessary treatment every six months or at least once a year in addition to a thorough application of the toothbrush two or three times a day. Again, users of tobacco should practice good oral hygiene, because the combustion products of tobacco are often the origin of chronic irritation to these tissues.

Symptoms: Patients suffering with this disease as a rule seek treatment late in the disease. A mouth lesion which has existed for four months or longer is considered advanced because it has a tendency to metastasize early to the regional lymph nodes. This disease will manifest itself by a swelling or a thickening of the mucous membrane of the mouth, or by an ulceration—the depth and extent of which depends on the type of growth or the length of time it has existed. These symptoms occur in the gum, the cheeks, or the floor of the mouth, or they may even involve the tonsils and the postnasal space. At first these lesions cause no pain except a possible slight irritation. Only after the ulceration has become secondarily infected by the bacteria normally found in the mouth does the patient sense pain or discomfort. A patient who has an ulceration or any abnormal condition in the mouth which persists longer than ten days or two weeks should seek prompt medical advice. Cancer in this area is very likely to metastasize to the glands of the neck, and often patients will ignore the slight ulceration in the mouth but will become alarmed about the enlarged glands of the neck.

Cancer of the tongue usually appears as a grayish or yellowish white elevation on the edges or the tip of the tongue. It is rarely confined to the dorsum of the tongue without the edges being involved. This, like mouth cancer, is only slightly irritating until the elevation ulcerates, becomes infected, and involves large areas of the tongue—even at times crossing the midline. Then pain will be experienced, and because of the inability

of the patient to move his tongue, difficulty will be encountered in talking, swallowing, and mastication. This type will also metastasize to the regional lymph nodes.

Treatment: Many patients endeavor to treat cancer of the mouth and tongue by means of iodine, silver nitrate, mercurochrome, and other drugs. The tissues of the mouth are too delicate to withstand these hard solutions. This is one important fact that is stressed in popular education. Nurses should discourage the use of these remedies and recommend proper medical care.

Surgery in the treatment of mouth cancer is gradually losing its popularity in favor of the modern methods of radiation with radium and x-ray. All types of radiation are used on these lesions. The early lesions are of course more amenable to treatment than the advanced ones. This is a type of malignancy which should receive attention at the earliest possible moment.

Much work must be done in order to spread the gospel of cancer control. The doctor and nurse hold the key positions in this combat. They need to become cancer conscious and to realize that cancer is curable and preventable and that the medical profession can offer these patients more help than ever before. However, they must be assisted in this struggle by prompt action on the part of the patient whenever he notices any unusual symptom. Nurses can aid materially by personal contacts if they are familiar enough with the cancer problem to answer questions accurately and to direct the patient to proper medical care.

One method of persuading the public to be on the alert for cancer symptoms is through popular education. Many public health nurses make it part of their responsibility to interest various groups in having talks on cancer by competent physicians or surgeons. Public-health-cancer education is becoming very popular. People are clamoring for this knowledge especially when they have had experience with this malady among their families or friends. Cancer education must be sponsored by the medical and nursing professions. It is our responsibility to see that patients seek treatment early at the time when cancer responds most readily to therapy.

REFERENCES

Stout, Arthur P. Human Cancer. Lea and Febiger, Philadelphia, 1932.

Tobey, James A. Cancer: What Everyone Should Know About it. Alfred A. Knopf, New York, 1932.

This is the second of a series of three articles by Dr. Kress on various aspects of the problem of cancer. The third article will appear in the April issue.

(To be continued)

THE AMERICAN JOURNAL OF NURSING FOR MARCH

Health Department Nurses Study Syphilis

By BRIDE LEE CAWTHON, R.N.

An official agency develops a staff education project based on the day-by-day needs of the nurses in carrying on their part of the syphilis control program

A STAFF EDUCATION program has been carried on by the nursing personnel of the Department of Health of Memphis, Tennessee, for the past five years. Topics for study have been selected according to current needs. The methods used are illustrated by a recent study program on the subject of syphilis which will be described here.

The Memphis Department of Health functions under the medical supervision of a superintendent of health. The nursing division is composed of a director of nurses and forty-five staff members, sixteen of whom are Negro nurses. The division works in close coöperation with all branches of the health department, especially the department of epidemiology and preventable diseases. The nursing service is conducted on the generalized plan and includes bedside nursing care in the home as a regular part of the work. School nursing and a home delivery service are also included in the program.

"PLEASE TELL US . . . "

Following the publication of Dr. Thomas Parran's article on syphilis in the *Survey Graphic,** and his book, *Shadow on the Land: Syphilis,*** the local newspapers gave an unusual amount of editorial and news space to the subject. As a result of this publicity the Department of Health was besieged with questions relating to syphilis. Requests for talks came from parent-teacher associations, churches, and other community groups. Children in the elementary schools asked the nurse: "What about this new disease? My mother and father said to ask you." The Negro prenatal patients had questions: "Nurse, they said at the clinic I has bad blood; does that mean I has this syphilis?" The adolescent group in the junior and senior high schools visited the department epidemiologist seeking information and presenting problems which were referred to the nursing staff for home follow-up. All of these questions had to be answered. There was a need for knowledge based on scientifically sound information. It was, therefore, important that the nurses become better informed on this subject.

Certain conditions necessary for a real staff education experience were defined in an article by Virginia Jones in PUBLIC HEALTH NURSING:

> First, the need for the program should be recognized by all members of the group; second, all members should make some contribution which involves initiative on their part; and third, each member must be able to apply what she has learned, so as to make her service to her families, community, and organization more productive of results and also to further her own growth.*

*Parran, Thomas. "The Next Great Plague to Go." *Survey Graphic,* July 1936. Also reprinted in *The Reader's Digest* in July 1936 as "Why Don't We Stamp Out Syphilis?"

**Parran, Thomas. Shadow on the Land: Syphilis. Reynal and Hitchcock, New York, 1937.

*Jones, Virginia. "A Staff Education Program Is Born." PUBLIC HEALTH NURSING, January 1937.

These three principles were observed in planning and in carrying out the educational program on syphilis. The nurses met the challenge of this new problem with characteristic courage and an eagerness to learn all they could in order to be better prepared for their job. All the staff workers contributed to the program, each in accordance with her particular ability. Learning became reciprocal; the nurses learned from each other—staff nurse and executive alike. The study program was planned to cover thirty hours.

Recognized methods of teaching universally used in adult education were followed. The program included reading, lectures, open discussions, laboratory experience, and clinic work. All meetings were carefully planned at least three months ahead in order to give the leader of the discussion ample time to make proper preparation. As the study progressed it became a matter of personal pride on the part of each staff member to make her individual contribution equal to or better than the previous one. "Why don't we stamp out syphilis?" became the theme song for the program.

It would not be correct to give the impression that a perfect "learning situation" existed. When the study began there was evidence of a deep-seated prejudice on the part of some of the staff members against an open discussion of syphilis and an acceptance of it as a communicable disease. Consequently, an effort was made to develop a philosophy which would break down the association of syphilis with moral behavior.

SELECTION OF TOPICS

The topics listed below were discussed in the order given, the selection being made on the basis of requests from the staff growing out of their felt needs. These needs arose from community demands for nursing service in the control of syphilis. The study program was based on the broad concept of the public health nurse's function as a "potential molder of public thought" and "something more than a technician performing a mechanical role in the management of the sick."* In assigning the topics to various staff members who would act as discussion leaders, consideration was given to the special interests and ability of each nurse.

Introduction to syphilis as a communicable disease—not as a moral issue
Education in sex life, preparation for parenthood, and the prevention of syphilis
History, cause, and prevalence of syphilis
Review of article, "Why Don't We Stamp Out Syphilis?"
Course of the disease: stages of syphilis
Syphilis as it relates to marriage and the family
How and what to teach the family regarding syphilis
Demonstration of nursing procedures in the care of syphilitic patients in the home
Syphilis in pregnancy and in the newborn infant
Infectiousness of syphilis
General principles and technique of treatment
Case studies
Demonstrations of diagnostic tests for syphilis
Syphilis in relation to maternal and infant mortality; stillbirths in the United States, and in Memphis
Syphilis and mental diseases

Each nurse was requested to keep a notebook of reference materials. It was surprising to find how much interesting material—including pamphlets, graphs, and posters—was accumulated by members of the group.

MANY EDUCATIONAL RESOURCES

In addition to the group discussions under the leadership of staff members, other educational resources were used. The Department of Dermatology of the University of Tennessee arranged for

*Stokes, John H. Dermatology and Syphilology for Nurses. W. B. Saunders Company, Philadelphia, 1935.

small groups to observe a diagnostic and treatment clinic. The class met on one occasion at the city laboratory where the laboratory director and his staff demonstrated the technique of the Wassermann, Kahn, Kline, and darkfield tests. The county medical society invited the nursing staff to a regular monthly meeting when a symposium on syphilis was presented. The director of venereal disease control of the State Department of Public Health showed the picture, "For All Our Sakes," which was followed by a round-table conference. A report of the Washington conference on venereal disease control called by the surgeon general was made by the superintendent of health.

Although Stokes' *Dermatology and Syphilology for Nurses* served more or less as a textbook for the study, many other references were used. Such sources of information as the United States Public Health Service, the American Social Hygiene Association, the Metropolitan Life Insurance Company, and articles in PUBLIC HEALTH NURSING were found to be very helpful.

At the completion of the study a written examination was given and the findings from these tests are being used as a basis for planning subsequent study on the subject.

This period of study was a valuable and enjoyable experience and one that stimulated individual interest in regard to syphilis as a family health problem. A nonvenereal viewpoint in regard to syphilis was instilled in the mind of the nurses. More freedom in the discussion of the disease is evident. The vocabulary of the nurse has been enriched. At the completion of the study program, 45 members of the staff (29 white nurses and 16 Negro nurses) decided to have Wassermann tests made by the department epidemiologist. Finally, there is evidence that the knowledge gained by the nurse has been translated into terms of service and that a more scientifically sound, more interesting, and more effective program has resulted.

PROGRAM ON OBSTETRICS AND GYNECOLOGY

MATERNAL HEALTH from premarital and preconceptional care through the entire maternity cycle will be discussed at the nursing sessions of the American Congress on Obstetrics and Gynecology, which will meet in Cleveland, Ohio, September 11-15. Specialists in all phases of maternity care will participate in the program, which is of special interest to public health nurses.

Topics to be discussed include antepartum, delivery, and postpartum care of the maternity patient; care of the newborn, and care of the premature baby; maternity care in rural areas; public education on maternity care; preparation of the nurse for obstetrical nursing including undergraduate and postgraduate education, and midwifery training; care of the unmarried mother; and socio-economic aspects of maternity care.

The membership fee of $5 payable to Dr. R. W. Holmes, 650 Rush Street, Chicago, Illinois, includes a year's membership in the American Committee on Maternal Welfare and registration in the American Congress on Obstetrics and Gynecology.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HONOR ROLL

All public health nursing agencies, including one-nurse services, are eligible for the N.O.P.H.N. Honor Roll. As soon as an agency sends word to the N.O.P.H.N. that all nurses on the staff are 1939 members, an Honor Roll Certificate will be sent and the name of the nursing service will be published in PUBLIC HEALTH NURSING. The name will appear only once, as the list published shows only those nursing services which have achieved 100 percent enrollment since the publication of the previous list.

. . .

We are proud indeed to be able to have so many names on our first published Honor Roll List in 1939. We know that there are many more agencies who have now achieved 100 percent enrollment, but who have neglected to send us word. Do write in as soon as possible and have the name of *your* agency on our next list.

Please note that there has been a change in the method of listing. The names of the agencies who have been on the Honor Roll list for five years or more are indicated with a star; those less than five years are not starred.

ALABAMA
- Pickens County Health Department, Carrollton
- Talladega County Health Department, Talladega
- Elmore County Health Department, Wetumpka

CALIFORNIA
- Metropolitan Life Insurance Nursing Service, Richmond

COLORADO
- *Visiting Nurse Association, Denver
- La Plata County Public Health Nurse, Durango

CONNECTICUT
- Public Health Nursing Association, Easton
- *Public Health Nurse Association, Darien
- Public Health Association of the Town of Essex, Ivoryton
- *Visiting Nurse Association, Waterbury

DISTRICT OF COLUMBIA
- Metropolitan Life Insurance Nursing Service, Suburban Washington

GEORGIA
- Toombs County Health Department, Lyons

ILLINOIS
- Metropolitan Life Insurance Nursing Service, Granite City
- *Ogle County Tuberculosis Sanatorium Board, Oregon
- Metropolitan Life Insurance Nursing Service, Waukegan

INDIANA
- Steuben County Health Department, Angola
- Lake County Health Department, Crown Point
- *Visiting Nurse League, Fort Wayne
- Allen County Anti-Tuberculosis League, Fort Wayne
- LaGrange County Health Nursing Service, LaGrange
- *Public Health Nursing Association, Richmond
- *Public Health Nursing Association, Terre Haute
- LaPorte County Public Health Nursing Service, Union Mills

KANSAS
- Finney County Red Cross, Garden City
- Public Health Nursing Association, Salina
- *Public Health Nursing Association, Inc., Topeka

LOUISIANA
- Rapides Parish Health Unit, Alexandria
- Jefferson Chapter Nursing Service, American Red Cross, Gretna

MAINE
- Androscoggin Anti-Tuberculosis Association, Lewiston
- Metropolitan Life Insurance Nursing Service of Bangor, Old Town
- *South Franklin County Nursing Service, Wilton

MARYLAND
- Metropolitan Life Insurance Nursing Service, Annapolis

Metropolitan Life Insurance Nursing Service, Baltimore

MASSACHUSETTS

*Canton Hospital and Nursing Association, Canton
*Visiting Nursing Association of Fitchburg, Fitchburg
*Watertown District Nursing Association, Watertown
Board of Health, West Springfield

MICHIGAN

Ottawa County Health Department, Grand Haven
The Greater Lansing Visiting Nurse Association, Lansing
Genesee County Health Department, Flint
*Visiting Nurse Association, Saginaw

MINNESOTA

Northfield Public Schools, Northfield

MISSOURI

*Metropolitan Life Insurance Nursing Service, Clayton
Metropolitan Life Insurance Nursing Service, Columbia
Cass County Health Unit, Harrisonville
*St. Joseph Organization for Public Health Nursing, St. Joseph
*Municipal Visiting Nurses, St. Louis
Board of Education, Division of Hygiene, St. Louis

MONTANA

Teton County Nursing Service, Choteau
Crippled Children's Division, State Department of Public Welfare, Helena

NEBRASKA

Nebraska State Planning Board, Kearney

NEW HAMPSHIRE

*Concord District Nursing Association, Concord

NEW JERSEY

Metropolitan Life Insurance Nursing Service, Asbury Park
Maywood Public School, Maywood
North Bergen Nursing Service, Ramsey
New Jersey State Department of Public Instruction, Trenton

NEW YORK

Metropolitan Life Insurance Nursing Service, Cortland
Seneca Falls Metropolitan Life Insurance Nursing Service, Geneva
Metropolitan Life Insurance Nursing Service of Babylon, Hempstead
Metropolitan Life Insurance Nursing Service, Herkimer and Little Falls
Metropolitan Life Insurance Nursing Service, Hudson
Metropolitan Life Insurance Nursing Service, Lancaster
*National Organization for Public Health Nursing, New York
*National Society for the Prevention of Blindness, New York

NORTH CAROLINA

Metropolitan Life Insurance Nursing Service, Durham
Robeson County Department of Health, Lumberton

OHIO

Metropolitan Life Insurance Nursing Service, Ashtabula
American Red Cross Public Health Nursing Service, East Liverpool
Metropolitan Life Insurance Nursing Service, Elyria
Public Health Nursing Department, Massillon City Hospital, Massillon
Metropolitan Life Insurance Nursing Service, Middletown
Metropolitan Life Insurance Nursing Service, Steubenville

PENNSYLVANIA

American Red Cross, Montrose Chapter, Montrose
*Visiting Nurse Association, Reading
American Red Cross, Southern Schuylkill Chapter, School Nursing Service, Tremont

RHODE ISLAND

Metropolitan Life Insurance Nursing Service, Newport
American Red Cross, Tiverton Chapter, North Tiverton
*Burrillville District Nursing Association, Pascoag

SOUTH DAKOTA

City Schools, Sioux Falls

TENNESSEE

Bledsoe-Sequatchie Public Health Unit, Dunlap
Dyer County Health Department, Dyersburg
*Davidson County Health Department, Nashville
*Metropolitan Life Insurance Nursing Service, Nashville
Gibson County Department of Public Health, Trenton

VERMONT

Metropolitan Life Insurance Nursing Service, Rutland

VIRGINIA

Metropolitan Life Insurance Nursing Service, Portsmouth
Metropolitan Life Insurance Nursing Service, Roanoke
American Red Cross, King William County, West Point

WASHINGTON

*Metropolitan Life Insurance Nursing Service, Tacoma

WISCONSIN

Neenah Health Department, Neenah

WYOMING

Lincoln County Public Health Nurse, Kemmerer

WITH THE STAFF

Since January was a month of many meetings, the staff did not go far afield. In February more field trips were made.

Dorothy Deming spent January 13 in Wilmington, Del., where she spoke at the meeting of the State Nurses' Association. The following day, she went to Washington, D. C., to attend the meeting of the Advisory Board on Public Health and Child Welfare called by the General Federation of Women's Clubs. January 18 was spent in Kentucky speaking at the annual luncheon meeting at the Public Health Center in Lexington and attending the annual meeting of the Public Health Nursing Association in Louisville.

Ruth Houlton went to Easton, Pa., on February 6 to give consultation service to the lay groups in that city. From February 14 to March 1 she was in Washington, D. C., giving consultation service to the American Red Cross.

Evelyn Davis spent January 30 in Fairfield, Conn., where she spoke at the annual meeting of the Visiting Nurse Association. On February 9, she went to Atlantic City, N. J., to conduct a discussion meeting for board members of that area. She went to Westfield, N. J., on the 14th to speak at the board meeting of the District Nursing Association.

Virginia Jones spent most of February visiting public health nursing courses at various universities and helping visiting nurse associations with their staff education programs. She visited Skidmore College in Saratoga Springs, N. Y., and the University of Buffalo, Buffalo, N. Y., and attended committee meetings in Cleveland, Ohio, and Detroit, Mich. At Madison, Wisc., she visited the University of Wisconsin and helped the local visiting nurse service with the student and staff education program. She visited the University of Minnesota in Minneapolis, Minn., and assisted the Visiting Nurse Association in Omaha, Nebr., with plans for staff education.

Dorothy Wiesner, our statistician, went to White Plains, N. Y., to study the statistical service of the Westchester County Health Department on January 12. From the 17th till the 19th she was in Syracuse, New York, securing data for a study of tuberculosis records.

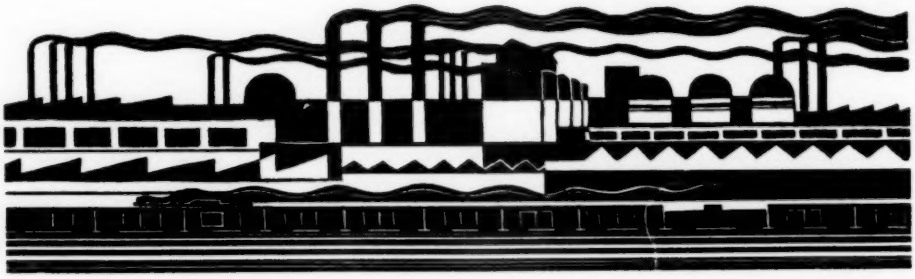
N.O.P.H.N. INCOME AND EXPENSE

1938

Income	
Membership dues, individual	$ 30,132.00
Membership dues, agency	24,260.18
Contributions	22,832.30
*Magazine	23,169.62
Reimbursements	4,300.06
Miscellaneous	9,662.45
Total income	**$114,356.61**
Expense	
Correspondence and Consultation	$ 31,026.87
Field Service	20,022.76
Educational Service	9,790.55
Statistical Service and Studies	9,685.55
*Public Health Nursing Magazine	
a. Advertising	2,352.16
b. Preparation	6,822.84
c. Printing	7,566.69
d. Subscriptions	7,763.76
Publications and Bulletins	9,317.56
Community Nursing Service	1,900.00
Biennial Nursing Convention	4,071.83
Total expense	**$110,320.57**
Summary	
Income	$114,356.61
Expense	110,320.57
Income over expense	**$ 4,036.04**
Life Memberships received for 1938	$ 570.00

*Public Health Nursing Magazine

Income	
Subscriptions	$18,611.87
Advertising	4,557.75
Total income	$23,169.62
Expense (allocated)	
General administration	$13,280.16
Travel	201.51
Printing and miscellaneous expense	10,171.17
Subscription promotion	852.61
Total expense	$24,505.45
Summary for magazine	
Expense	$24,505.45
Income	23,169.62
Deficit	$ 1,335.83



USING OUR COMMUNITY RESOURCES

Do we, as industrial nurses, know our various agencies and how they function? Do we know the channels through which we must go to gain our objectives? Do we utilize the activities placed at our disposal? We should know our tools and how to use them.

Industry is the hub of the community, and the community takes its color more or less from the type of work carried on there. A city that sells insurance is different from a city that manufactures iron, steel, coal, cotton, or silk, and their problems are different. It is important that we know our city or town as a whole, in order to plan and evaluate our services.

We are the central agency for the industrial worker, so to speak. We hear the problems first-hand, but we must rely on community agencies to carry on our work successfully. As the industrial nurse, we are supposed to be a composite being—a combination of teacher, social worker, mental hygienist, and nurse. Because of the confidence placed in us it is imperative that we know our community resources and how they function.

For instance, in most states we have at our disposal, under the state department of health, the different bureaus. There are bureaus of:

Preventable diseases
Sanitary engineering
Laboratories
Child hygiene
Public health nursing
Syphilis and gonorrhea
Mental hygiene
Nutrition
Occupational diseases

The bureau of occupational diseases maintains a consultation service for physicians, social case workers, industrial nurses, and others interested in health in industry.

Other state agencies, institutions, and workers that we may use include:

Tuberculosis sanatoria

Schools and home teachers for the deaf and hard of hearing

Schools and home teachers for the blind and visually handicapped

Agencies, schools, special classes, and occupational-therapy programs for the crippled

Child welfare agencies and child welfare activities of health and welfare organizations

Social case work organizations and medical social work departments of hospitals—nonsectarian, Catholic, and Jewish

Public welfare agencies—including administration of mothers' pensions and old-age assistance

Recreational agencies, such as the Young Women's Christian Association, Young Men's Christian Association, Boy Scouts, Girl Scouts, and settlements

Institutions and agencies for the care of the sick—hospitals, clinics, and visiting nurse associations

Legal aid bureaus

Mental hygiene services and child guidance clinics

The state department of education frequently has responsibility for vocational education, vocational rehabilitation, and adult education.

Our work should be closely correlated with that of the school nurse, the visiting nurse, and other public health nurses in the community, and with that of the

social workers. We should each know how the others function in order that we may give effective service and avoid overlapping.

Health departments and nursing organizations in many communities now offer classes in the evening for expectant fathers to enlighten them regarding the care of the mother and child. Until recently health agencies did not pay much attention to fathers, except to boast that they "never lost a father."

We should be vitally concerned with the needs of partially or permanently disabled persons, and should be able to refer them to the proper places for vocational guidance in order that they may be fitted for positions where they can be gainfully employed.

Community chests, councils of social agencies, and local and state social and health organizations offer us every opportunity to gain an understanding of community relationships. There is not one activity mentioned that we cannot use advantageously at some time or other.

Let us go back to our plants, take stock of ourselves, and see whether we are really using our community agencies to give better service to our workers and their families.

WINIFRED HARDIMAN, R.N.
The Terry Steam Turbine Company, Hartford, Connecticut

Presented before the joint conference of the New Jersey, New York, Philadelphia, and New England Industrial Nurses, New York, N. Y., October 29, 1938.

HOW DERMATITIS WAS REDUCED IN OUR PLANT

THE CAUSES of industrial dermatitis include a lack of cleanliness, allergic reactions, and exposure to various irritating substances.

Industrial dermatitis is steadily being reduced in our plant, due principally to the emphasis put on safety education. Since the prevention of dermatitis is far better than care after the damage is done, it is the nurse's concern to recognize any poisonous or deleterious materials, dusts, vapors, gases, or fumes, and to note violations of working standards.

With the coöperation of the superintendent and the foremen of the various departments, a number of hazards have been eliminated.

A new exhaust system was installed in one department to carry off vapors and fumes. The shower-room was rebuilt, and an excellent soap—used in powdered form because of the scouring effect—was furnished. Cream for the use of hands and arms, rubber gloves, and goggles were ordered where necessary.

An oil containing a cheap chemical disinfectant is now used in our machines, thereby eliminating infections and eruptions.

Sodium cyanide and potash are used extensively in production; therefore, a daily inspection of the operators handling these materials was inaugurated. Any bruises, scratches, or burns are treated and dressed in order to prevent contamination.

When our new trichlorethylene degreasing machine was installed, many problems relative to the solvent trichlorethylene arose. To protect the operator and others around this machine, the advice of experts who were informed on this solvent was sought. In conjunction with representatives from our insurance company and the company from whom the machine was purchased, the location of the machine and other details necessary for greatest safety were worked out. The operator was then given a full course of instructions in how to use the machine, and up-to-date publications of reputable laboratories were furnished.

All of these precautions have eliminated any danger to the operator as well as to the men and women working in the near vicinity of the degreasing machine.

Any skin eruption noticed at the time of employment is referred to the physician for diagnosis.

Several classes in hygiene have been conducted for the girls of the factory. Previous to the lectures many of the girls hesitated to seek the advice of their doctor about various skin eruptions. Now they secure medical advice for such conditions in their early stages.

FRANCES A. HARRINGTON, R.N.
The Wahl Company
(Eversharp Pens—Pencils)
Chicago, Illinois

A WORKER SPEAKS HIS MIND

WELL DO I remember the dav when I had my first conversation with our industrial nurse. Her simplicity and friendly conversation made me feel at home from the first day I met her. Knowing that I was an immigrant from Germany, I was greeted by her in German. She explained to me all the opportunities a young man or woman has in the United States. Her pointers on education were full of interest and enthusiasm which was carried over to her listener. Gladly do I admit that the credit for my receiving a diploma from the evening high school last June is all hers.

Anyone who seeks advice on almost any problem will find her a willing listener. No matter how pressing her work is, she will take time out to help anyone who needs it. She assists the sick and the injured, sees to it that the right employees are chosen if a blood transfusion becomes necessary to save the life of a fellow employee, makes it her business to see that employees who retire from the service receive a hearty farewell, and performs a multitude of other tasks which make her beloved.

The service which our industrial nurse renders to the employees of one of the largest packing plants can only be appreciated by one who has known her and is given an opportunity to become acquainted with her ideals.

A. FRISCHE
A Worker
Chicago, Illinois

WHAT ARE THE EYE HAZARDS IN YOUR PLANT?

THE NATIONAL Society for the Prevention of Blindness has issued a call for (1) information concerning new occupational eye hazards (2) recent and significant statistics concerning any occupational hazards to sight—showing frequency, severity, causes, nature of injury, degree of impairment, and cost (3) photographs showing either hazards to sight or protection against such hazards (4) information concerning successful methods of eliminating, counteracting, or alleviating the disease and accident hazards to eyes. The Society's headquarters are at 50 West 50 Street, New York, N. Y.

This information is desired for consideration in the revision of "Eye Hazards in Industrial Occupations," which for more than ten years has been the standard handbook on the subject among safety engineers, industrial physicians, nurses, and executives, and all those professionally concerned with the conservation of vision among workers.

The task of bringing the handbook up

to date has been given to Louis Resnick, industrial relations consultant of the organization. Mr. Resnick is now in Europe, where he will analyze the data on this subject assembled from fifty countries by the International Labor Organization and the Health Section of the League of Nations in Geneva and by the industrial safety organizations of Great Britain, France, Switzerland, and other European countries.

The National Society for the Prevention of Blindness is a nonprofit-making, noncommercial organization. During the past fifteen years it has served as a clearing house of information on industrial eye protection. Its contribution to this important field depends to a large extent on the coöperation and help it receives from the industrial and public health groups which are interested in these problems.

MEDICAL DIRECTION IN A SMALL PLANT

"How can medical direction be secured in a plant too small to make possible a salary to a medical director?" This question was raised at the industrial nursing session of the 1938 National Safety Congress, in connection with Dr. Melvin N. Newquist's discussion on the importance of medical direction of the nurse's activities. (See page 162 for Dr. Newquist's paper. See December issue, pages 730-731, for report of National Safety Congress, Chicago, Illinois, October 13, 1938.)

"I am Scotch," said a nurse with a sense of humor and a strong Scotch accent, speaking from the floor. "Tell me how one can get a medical director for little or no cost."

"There are medical men in any community sufficiently interested in industrial health to serve as medical director of a small plant for a minimum charge or without additional recompense if they are already making physical examinations and treating the injured for the plants in question," replied Dr. Newquist. "A consultant service to a plant does not require much time. The physician may be given the title of 'medical director' and may be called upon for advice as problems arise. The nurse will then have medical direction and someone to approve the standing orders under which she works."

"Won't there be a problem in selecting a local physician without causing offense to the others?" asked another questioner from the floor.

"The local physicians can be rotated, asking one to serve each year," suggested Dr. Newquist. "The honor and the responsibility can then be shared by all who are interested in doing industrial work."

Editor's Note: A further discussion by Dr. Newquist on medical direction in a small plant will appear in this section in a later issue.

PICTURES WANTED

We need pictures showing different phases of industrial nursing. Not only are they wanted to illustrate articles in the magazine, but the N.O.P.H.N. is constantly receiving requests from the field for the loan of industrial nursing pictures. If you have any good glossy prints, won't you send them to us?

See page 162, "Industrial Nursing—Past, Present, Future," by Dr. Melvin N. Newquist.

HIGH POINTS in SCHOOL HEALTH

HEALTH IN THE MODERN MANNER

By PHYLLIS ROSENTEUR

The story of a health course in the Weequahic High School in Newark, New Jersey, told by a student in the class

ONE DAY late in June, Room 127 was buzzing with audible excitement. Parents and teachers had come in to see the culmination of a term's work in health. The senior girls, having prepared the program, were seating the guests and—seemingly undaunted by the fact that they were going to demonstrate to their own mothers the fine art of rearing children—proceeded to show that they themselves were no longer babies but young women to whom every young man seemed a prospective husband.

Young potential mothers

This whole program was the result of five months of study in regard to the problems facing the young girl and the subsequent perplexing questions of motherhood.

Each girl had selected a study child of any age between one day and five years from among her circle of small friends. The class discussions centered around the care and training of these children. These discussions grew out of considerable library study, some notebook work and as much actual participation in the guidance of the child's life as possible. Each girl watched—not casually but minutely—the antics of her observation babe. Sometimes the conversations between mother and child were recorded word for word so that the reactions of the child to his mother's commands or his receptivity to the answers to his questions could be discussed in class. Oftentimes the students would bring up points and prove them by referring to the actions of the children. The topics covered by this triple method of study—outside reading, class discussion, and home study of the chil-

Demonstrating the baby's bath

dren—included obedience, punishment, various types of lies, curiosity, play, self-reliance, cleanliness, food, and other subjects that have to do with the formation of a healthy mind and sound body in a child.

Finally, they came to those important questions which have been discussed so often: What are wholesome boy and girl relationships? What should one look for in choosing a mate? Should the mother of small children work outside the home? The first two were among the most enjoyable discussions which the members of the health class participated in, for we were just at that age when we could so profitably and happily talk over our present and future relationship with the other sex.

Last but most important were subjects pertaining to motherhood. Delving to some extent into prenatal care, we learned something about the protection of the skin, regulation of elimination, rest, and the clothing of the mother-to-be. How familiar! They were the same admonitions we heard so much about in our former course in personal health, but how much more they struck home now. The prevention of disease, including syphilis in newborn babies, came in for its share of discussion. The advantages of breast feeding over bottle feedings caused a run on the library and taxed the memories of the pupils' mothers. Then we began actual demonstrations in bathing and dressing the infant. Our equipment was that of a model nursery but our children were of the kind that never grow up—dolls that were very life-like, with movable limbs and waterproof skins. In the course of only a few short months we have become confident that we are really proficient mothers, proficient enough to invite professionals to view the work of amateurs.

SCHOOL HEALTH SECTION

For some time the material on school health has overflowed the school health section as the needs of this field have broadened and good available material has increased. The Publications Committee at its annual meeting on January 24 decided that the material of interest to school nurses has outgrown the scope of a department and the section will therefore be discontinued beginning in April. A guide calling attention to articles of special value to school nurses will be published monthly.

EDITED BY
ELLA E. McNEIL

PARENTS IN PERPLEXITY

By Jean Carter. 143pp. American Association for Adult Education, New York, 1938. $1.

This is a report of one of the series of studies in the social significance of adult education in the United States sponsored by the American Association for Adult Education. For those who want to know something of the implications of parent education this book will prove a profitable and stimulating guide.

The report points out that "Twentieth-century American parents have a multiplicity of racial heritages, and, in addition, they have had to live in a period of rapid change to which they have not only had to attempt continuous adjustment for themselves but also have been utterly bewildered as to what their children would meet in the future."

Almost every voluntary and official agency has recognized the plight of parents and is trying to do something about it. "It is a rare community," states the author, "in which there are fewer than three organizations dabbling in parent education and even rarer is the community in which there is any effective attempt at integration."

The large part played by lay leaders and the contribution of professional workers in the development of parent education are described. Upon the latter the author places the responsibility for the future course of this "folk movement." She points out that "the eagerness of some of them to promote a particular kind of program through mass instruction and their impatience with the slowness of the democratic process constitute a threat to the democracy which is inherent in the movement and fundamental to it if it is to realize its possibilities." "Are they," she concludes, "like so many other educational groups, using the techniques of democracy to superimpose the more effectively an orderly dictatorship?"

LOUISE STRACHAN
New York, New York

THE INFANT

A Handbook of Modern Treatment

By Eric Pritchard, M.D. 744 pp. William Wood and Company, Baltimore, 1938. $6.

Although the author asserts very firmly in the introduction that this book is designed to be used only as a reference work on treatment, much of value may be found in the descriptions and comments, introductory to each of the wide range of conditions dealt with. The author undoubtedly calls upon a rich experience for the material found in these introductions; they are not an unimportant part of the book.

As a reference on treatment, the book, which was originally published in England, might well be used in conjunction with other texts unless the reader is already familiar with the practices commonly taught in our own country. The text might better be used to supplement other reading than to take the place of it. The chapters on nutrition and breast feeding and the first half of the chapter on artificial feeding are exceptions to the remainder of the book in this respect. They can stand alone and might be read undiluted by reading from other sources.

The manner in which the nutritional

diseases are approached is of great interest. Eight pages are devoted to the excess diseases. This is just a little aside from the beaten path in the study of nutrition as presented in this country.

PERCY F. GUY, M.D.
Seattle, Washington

CARING FOR THE RUN-ABOUT CHILD

By Rhoda W. Bacmeister. Photographs by Tom Maley. 263pp. E. P. Dutton and Company, New York, 1937. $2.50.

This is a delightful and practical book. The author is both a mother and a nursery school teacher and consequently is fully acquainted with the guidance of children from two to six years of age, which she describes as the "run-about age" because the child is so "occupied in exploration."

The catchy, popular chapter headings might lead one to suppose that this book lacked sound information. However, it is based on good judgment and keen observation, and nurses will enjoy reading it because it portrays the normal preschool child so naturally in all aspects of his living. They will discover principles to guide them in dealing with young children and in advising parents on such aspects of behavior as eating, sleeping, toilet-training, and nervous habits. Other chapters on the education of children through play, books and stories, and music will be found valuable. The chapter on sick children presents the need for a balanced point of view by the adult and child toward illness, and suggests clever, simple ways of occupying the ill or convalescent child.

FLORENCE DUHN
Detroit, Michigan

MENTAL HYGIENE IN OLD AGE

Family Welfare Association of America, 130 East 22 Street, New York, 1937. 50 pp. 40c.

The six papers published in this pamphlet were originally given as a series of lectures planned by the New York City Committee on Mental Hygiene, for the benefit of professional workers who are concerned with the care of old people.

The following topics are covered by authorities in their respective fields:

Family Life and Relationships as Affected by the Presence of the Aged
Psychological Factors in Old Age
Mental Hygiene Problems as They Emerge in Old Age Security
Types and Special Factors of Mental Illness in Old Age
Physical Illness and Mental Attitudes of Old People
Physiological Changes in the Process of Aging.

GLEE HASTINGS
New York, New York

FOUNDATIONS OF NUTRITION

By Mary Swartz Rose, Ph.D. 625pp. The Macmillan Company, New York, third edition, 1938. $3.50.

This third edition of a well known text, first published in 1927, is not only dressed up in a new binding but offers an up-to-date and readable exposition of the science of normal nutrition. In adding new material the author has sacrificed none of the delightful historical sketches and allusions to classic literature which characterized the earlier editions. From Nebuchadnezzar and Daniel to crystalline vitamins we follow the birth and development of a new science with keen interest.

Outstanding new developments in the science are presented in a manner suitable for beginning students. Data from recent studies on energy requirements of children and adolescents are included. The twenty-two amino acids present in common proteins, as well as the ten of these now recognized as essential for growth, are listed. The largest amount of new material is devoted to the vitamins. Very technical matters are quite rightly left to collateral references. The tentative estimates of vitamin requirements of humans in general conform to present concepts based upon human studies. An exception is the figure for

vitamin C requirement which is less than one tenth of the amount now considered as an optimum.

Whether or not one wishes to use the author's concept of shares in teaching food values there is no doubt that this device is excellent for demonstration purposes and the new colored plates show how such demonstrations may be made most effective. Unless a person is thoroughly familiar with the concept of shares, however, Table I in the appendix is limited in usefulness. A definition of shares might well be included in the explanation of this table.

The last few chapters are devoted to the nutritional needs of specific types or groups of people. At no time does the author lose sight of the practical application of nutrition principles in every day life. The book may well be recommended to the intelligent layman as well as to the teacher of elementary nutrition.

HELEN S. MITCHELL, Ph.D.
Amherst, Massachusetts

The Rural Community and Social Case Work by Josephine C. Brown has been reduced from $1 to 50 cents. Copies may be obtained from the Family Welfare Association of America, 130 East 22 Street, New York, N. Y.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

NUTRITION

NUTRITIVE ASPECTS OF CANNED FOODS. Compiled by the Nutrition Laboratory, Research Department of the American Can Company, 230 Park Avenue, New York, N. Y., 1937. 110pp. Free to physicians.

A bibliography of scientific reports and helpful tables of food data.

NUTRITION. Final Report of the Mixed Committee of the League of Nations on the Relation of Nutrition to Health, Agriculture, and Economic Policy. Columbia University Press, New York, 1937. 327pp. $2.

As a reference book this report furnishes invaluable material. The interrelationship of progress toward better nutrition and economic and educational factors is pointed out. The report states that through education "there is some scope for the improvement of dietary habits even in the lower income groups"; it also recognizes that nutritional problems are not limited to the low income group. Thus since the problem is largely educational the first step is to "educate those responsible for education and the administration of social aid." Part II considers nutrition and health, summarizing the latest data on nutritional needs and dietary standards; Part III discusses "recent trends in food habits." The book is nontechnical in presentation.

DIETS FOR ELDERLY PERSONS. Sue Sadow. Welfare Council of New York City, 44 East 23 Street, New York, October 1937. 19pp. 15c.

HOW TO FEED YOUNG CHILDREN IN THE HOME. Mary E. Sweeny and Dorothy Curts Buck. The Merrill-Palmer School, Detroit, 1937. 68pp. Free copies may be obtained from the Irradiated Evaporated Milk Institute, 307 North Michigan Avenue, Chicago.

LOW COST FOOD FOR HEALTH. Blanche F. Dimond. Community Health Association, 137 Newbury Street, Boston. 75pp. 25c.

Recipes and suggestions for planning attractive, healthful meals at low cost.

BUDGET STANDARDS FOR FAMILY AGENCIES IN NEW YORK CITY. Prepared by The New York Budget Council, Social Welfare and Public Health Department, New York City Home Economics Association, Room 302, 105 East 22 Street, New York, 1938. 42pp. 35c.

FOOD VALUES OF PORTIONS COMMONLY SERVED. Compiled by Anna De Planter Bowes and Charles F. Church, M.D. Philadelphia Child Health Society, Philadelphia, 1937. 12pp. 50c.

This handbook consists of tables showing the nutritional values of common foods. Good reference material for public health nurses.

DIET THERAPY SERVICE IN A PUBLIC HEALTH NURSING ORGANIZATION. Dorothy B. Hacker. *The Medical Woman's Journal*, 2334 Upland Place, Cincinnati, August 1938, p. 238.

The nutritionist on the staff of the Detroit Visiting Nursing Association describes her program which includes part-time or hourly nutrition visits as well as consultation service to the public health nursing staff.

NUTRITION IN HEALTH AND DISEASE FOR NURSES. L. F. Cooper, E. M. Barber, and H. S. Mitchell. J. B. Lippincott Company, Philadelphia, seventh edition revised, 1938. $3.

• An institute for directors of schools of nursing and nursing services will be held on June 15, 16, and 17 at The University of Chicago, Judson Court, 1005 East 60 Street, Chicago, Ill. The central theme of the institute will be "Current problems in educational administration in nursing." Copies of the program may be secured after April 1.

The institute is planned primarily for those engaged in administration in nursing, but will be open also to those engaged in teaching. The requirements for admission to the Department of Nursing Education will not apply to those who wish to register for the institute. A registration fee of $3 will be charged. Application for registration should be made at an early date by writing to Nellie X. Hawkinson, Department of Nursing Education, The University of Chicago.

Room and board will be provided in Judson Court for the period of the institute for $8.50. Reservations may be made through William J. Mather, Bursar, The University of Chicago.

• The forty-fourth annual conference of the American Association for Health, Physical Education, and Recreation, a department of the National Education Association, will be held April 3-6 in San Francisco, Calif.

•The University of California and the State Department of Public Health will offer a three-weeks' course in venereal disease nursing on the Berkeley campus, June 26-July 15.

Members of the staff of the Bureau of Venereal Diseases of the State Department of Public Health will lecture on medical aspects of the control of syphilis and gonorrhea. Mrs. Evangeline Morris, instructor in public health nursing, Simmons College, Boston, Mass., will teach a class on the part of the public health nurse in the control of these diseases.

Three units of credit will be given for the course, which is open to all nurses interested in this phase of public health. The fee for the three-weeks' study is $17.50. Registrations should be made through the University of California, Berkeley, Calif.

• During the week of April 10, Lum and Abner, radio rural team, will discuss over the Columbia Broadcasting System the opportunities for nurses today both in hospitals and in public health, and will pay tribute to the nursing profession. The Nursing Information Bureau will supply material for the broadcast. Lum and Abner are heard each Monday, Wednesday, and Friday night at 7:15 Eastern, 6:15 Central, 9:15 Rocky Mountain, and 8:15 Pacific Coast time.

• The Class of 1914 of the Boston Floating Hospital is planning to hold its twenty-fifth reunion on the same day as the annual meeting of the hospital, August 9. Members planning to attend should get in touch with Winifred Culbertson, superintendent, The Children's Convalescent Home of the Cincinnati Orphan Asylum, Auburn Avenue and Wellington Place, Cincinnati, Ohio.

Correction: In Official Directory of Public Health Nurses, January 1939.

North Dakota. (p. 64) Chairman, Section on Public Health Nursing of North Dakota State Nurses' Association—Olive Lee, District Health Department, Valley City.

List of course directors (p. 65)—Minnesota—Margaret G. Arnstein, Assistant Professor and Director of Public Health Nursing, Department of Preventive Medicine and Public Health, University of Minnesota.

Our Readers Say . . .

THIS COLUMN is intended to serve as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed on this page.

PNEUMONIA PROGRAM AROUSES INTEREST

We were very much interested in the nursing representation at the pneumonia nursing meetings held throughout New York State last winter. Of approximately 2000 nurses attending, over 1000 were private duty and hospital nurses. All of the nurses manifested a very real interest and apparent need in the specific aspects of pneumonia nursing, with particular reference to serum and oxygen therapy.

The professional staff of the Bureau of Pneumonia Control kept records of the questions asked, and have prepared the series of articles on these subjects which you are at present publishing in PUBLIC HEALTH NURSING. We have observed that nurses tended to concentrate on specific techniques of therapy rather than on the nature of their nursing care, and an effort has been made in these articles to balance their thinking in this respect. We have been gratified at your willingness to give the subject so much space in your journal. You have helped us immeasurably to reach that group of nurses whose interests are our primary concern.

MARION W. SHEAHAN
Director, Division of Public Health Nursing, New York State Department of Health

A NURSE IN THE MAKING

Although as yet I am a public health nurse "in the making," very soon I shall have completed my work at the university and will be ready to join the "happy family."

Your magazine has lent a helping hand all along the way. I enjoy each succeeding issue as much as I did the first copy that fell into my hands. I have used it as a textbook for the past two years in classes, and have never yet found it dull or boring. It is quite up to the minute in everything. The articles are well prepared and presented in an interesting way. It will continue to be my standby when I enter the field, both for reference work and new points of interest.

GRACE HANNEFIN
St. Louis, Missouri

STUDENT AFFILIATES LIKE WORK

The Newark Visiting Nurse Association has a student affiliation with two schools of nursing, and one of the questions which we ask them on completing their work, is "How has this affiliation been valuable to you?" Two students gave such good replies that I am sending them to you.

ANNA E. EWING
Director, Visiting Nurse Association, Newark, New Jersey

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My public health affiliation has aided me in innumerable ways. It has taught me how to find the reason for individual behavior and to understand motivations. It has taught me to be much more understanding and tolerant. I have seen the necessity for tact in every visit, in order to gain coöperation and to be useful to my patient. I believe the wide range of social and economic levels which I have seen has helped me in gaining poise and in becoming quickly adjusted to new situations because of the situations which we meet when "on our own." I believe I have also developed more fully self-reliance and the ability to judge accurately. I am sure that my public health affiliation has aided me very much professionally and personally.

HELEN SCHNEIDER
Beth Israel Hospital, Newark, New Jersey

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My affiliation here has made me conscious of numerous problems existing in the community of which I was not entirely aware before. I thoroughly enjoyed the work on the district because I feel that here more than in any other field of nursing, teaching can be exercised and results can be readily seen. Personally it has broadened my views. I feel justified in saying that I am sorry my affiliation here is over.

SYLVIA RUTH ALEXANDER
Beth Israel Hospital, Newark, New Jersey